STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	C 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments	E 000		

MEDICARE COMPLAINT SURVEY

The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482, conducted this health and safety survey.

Onsite dates: 03/05/18 to 03/09/18 and 03/12/18 to 03/15/18

Intake number: 79682

The survey was conducted by:

Lisa Mahoney, MPH, PHA
Kimberly Metz, MSN, BSN, RN
Elizabeth Gordon, RN, MN
Tyler Henning, ScM, MHS, PHA
Joyce Williams, RN, BSN
Paul Kondrat, RN, MN, MHA

During the course of this survey, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the extent of deficiencies. This resulted in two findings of IMMEDIATE JEOPARDY in the following areas:

1. The hospital did not develop and implement a system to ensure the safety of patients identified as being a danger to self or others (03/05/18, 4:30 PM)

2. The hospital failed to provide adequate monitoring of patients admitted for suicidal ideation or assessed at risk for suicide in order to

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 000	Continued From page 1 prevent future attempts (03/06/18, 4:45 PM) Removal of the state of IMMEDIATE JEOPARDY for Suicide Risk Asessment was verified on 03/13/18 5:12 PM by the DOH survey team. Removal of the state of IMMEDIATE JEOPARDY for Identification of Patients who pose a danger to self or others was verified on 03/14/18 at 12:30 PM by The DOH survey team. DOH staff found the facility NOT IN COMPLIANCE with the following Conditions of Participation: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient Rights 42 CFR 482.21 Quality Assessment and Performance Improvement 42 CFR 482.22 Medical Staff 42 CFR 482.23 Nursing Services	E 000		
E 007	EP Program Patient Population CFR(s): 482.15(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.**	E 007	**Plan of Correction for Each specific deficiency Cited:** (E007) The Hospital failed to provide a policy for providing treatment of special populations during an emergency. **Procedure/process for implementing the plan of correction:** • Policy for providing treatment of special populations during an emergency has been written and will be available under the emergency management section for policies. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Will be reviewed on an annual basis. • Plant operations manager will review the emergency plan and attachments on an annual basis. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance**	May 23,2018

			Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice: • The policy will be communicated to staff and educate on location to find. • Review and any possible revisions will be presented to the safety/EOC committee. After the emergency plan and attachments have been approved will go to the Performance Improvement committee (PI committee). **Individual Responsible:** Zach Keefe, Plant Operations Manager **Date Completed:** May 23, 2018	

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E 007	Continued From page 2 *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on observation and interview, the hospital failed to ensure that the emergency preparedness program adequately addressed the patient population. Failure to have policies and procedures addressing the patient population places patients at risk of injury or death in an emergency. Findings included: 1. Record review of the hospital document titled, "Emergency Operation Plan," showed that the hospital has a clinical services policy for providing treatment of special populations during an emergency. The policy was not included in the emergency operation plan documents. 2. On 03/13/18 from 10:00 AM to 11:20 AM, Surveyor #2 interviewed the Director of Plant Operations (Staff #201) and the Maintenance Technician (Staff #202) regarding the emergency preparedness program. The director stated that the special populations policy would be a clinical policy and was not in the master emergency plan document list. During the time of the survey, the hospital failed to provide the surveyor with the clinical policy addressing the patient population.	E 007		
E 018	Procedures for Tracking of Staff and Patients CFR(s): 482.15(b)(2) [(b) Policies and procedures. The [facilities] must	E 018		

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E 018	Continued From page 3 develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice	E 018	**Plan of Correction for Each specific deficiency Cited:** (E018) The Hospital failed to use a tracking form used to track patients in various circumstances during an emergency. **Procedure/process for implementing the plan of correction:** • Tracking forms will be used in emergency management situations and will be available to staff in the emergency management book located centrally on each floor in the nursing area. • HICS form 255 and 260 will be located in the EOP. • Staff will be identified and trained to participate in the incident command system. • Plant operations manager is currently taking the incident command ICS 100 FEMA course. • HR director has already completed the ICS 100, 200, 700, and 800, and National Emergency response and rescue training in disaster preparedness. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • EOP will be reviewed annually for compliance by the plant operations manager any revisions or recommendations will be presented to the Safety/EOC committee and then to	May 23,2018

			the PI committee. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice** • The forms will be reviewed post Emergency management drills. • Review and any possible revisions will be presented to the safety committee then reported to the PI committee. **Individual Responsible:** Zach Keefe, Plant Operations Manager **Date Completed:** May 23, 2018	

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E 018	Continued From page 4 employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure that the emergency preparedness plan accurately addressed the hospital policy for tracking patients during an emergency. Failure to ensure that the emergency preparedness plan adequately addresses the hospital policy for tracking patients risks the inability to adequately track patients in the event	E 018		

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E 018	Continued From page 5 of an emergency. Findings included: 1. Record review of the hospital document titled, "Emergency Operation Plan," showed that three tracking forms were to be used to track patients in various circumstances during an emergency. The forms were not found in the emergency preparedness program documents. 2. On 03/13/18 from 10:00 to 11:20 AM, Surveyor #2 interviewed the Director of Plant Operations (Staff #201) and the Maintenance Technician (Staff #202) regarding the patient tracking forms. The director stated that the forms are not used and a patient roster would be utilized for tracking purposes. The director confirmed that the patient tracking section of the emergency operations plan did not accurately address the process the hospital would use during an emergency.	E 018		
•	Arrangement with Other Facilities CFR(s): 482.15(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at	E 025		

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E 025	Continued From page 6 §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure that it had developed arrangements with other facilities to receive patients in the event of the limitation or cessation of operations. Failure to develop arrangements with other facilities regarding the transfer of patients places patients at risk from inadequate care in the event of the limitation or cessation of operations during an emergency.	E 025	**Plan of Correction for Each specific deficiency Cited:** (E025) The Hospital failed to update the policy to accurately reflect the location of the facility. **Procedure/process for implementing the plan of correction:** • The form was updated to local and state requirements. • SPBH is currently enrolling in WATrac which will include agreements of transfer during emergency operations. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Details of WATrac and policy updates will be communicated through the safety/EOC committee. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice** • The MOUs will be reviewed post Emergency management drills. • Any revisions or recommendations will be presented to the Safety/EOC committee then to the PI committee. **Individual Responsible:**	May 23,2018

			Plant Operations Manager **Date Completed:** May 23, 2018	

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E 025	Continued From page 7 Findings included: 1. Record review of the hospital document titled, "Emergency Operation Plan," showed that the facility did not develop prearranged transfer agreements with other facilities to receive patients in the event of an emergency that limits the ability of the hospital to adequately care for patients. 2. On 03/13/18 from 10:00 to 11:20 AM, Surveyor #2 interviewed the Director of Plant Operations (Staff #201) and the Maintenance Technician (Staff #202) regarding patient transfer agreements with other facilities. The director stated that no transfer agreements were in place, but the facility would rely on the regional hospital coalition to facilitate patient transfers. A defined memorandum of understanding with the regional health care coalition was not developed at the time of review.	E 025		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 482.15(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the	E 026		

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E 026	Continued From page 8 [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure that the emergency preparedness plan accurately addressed the hospital policy for use of alternate care sites. Failure to ensure that the emergency preparedness plan adequately addresses the hospital policy for alternate care sites risks the inability to adequately provide patient care in the event that an alternate location is needed. Findings included: 1. Record review of the hospital document titled, "Emergency Operation Plan," showed that information regarding alternate care sites was to be located in an appendix of the emergency operations plan. No appendix existed at the time of review. 2. On 03/13/18 from 10:00 to 11:20 AM, Surveyor #2 interviewed the Director of Plant Operations (Staff #201) and the Maintenance Technician (Staff #202) regarding the use of alternate care sites, specifically regarding the appendix that is	E 026	**Plan of Correction for Each specific deficiency Cited:** (E026) The Hospital failed to have the alternate care sites located in the appendix. **Procedure/process for implementing the plan of correction:** • The facility in enrolled region 1 healthcare coalition and WATrac. This will include alternative care sites per the MOU which will be printed and placed in the EOP. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • EOP will be reviewed on annual basis. • Any revisions or recommendations will be presented to the Safety/EOC committee then to the PI committee. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • Forms and procedures will be reviewed for post critique after emergency management drills. **Individual Responsible:**	May 23,2018

			Plant Operations Manager **Date Completed:** May 23, 2018	

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E 026	Continued From page 9 supposed to list information on alternate care sites. The director stated that no appendix exists and this portion of the plan should be amended to accurately reflect hospital operations.	E 026		
E 033	Methods for Sharing Information CFR(s): 482.15(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement	E 033		

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E 033	Continued From page 10 made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to ensure that its policy regarding disclosing patient information in an emergency was specifically developed for the hospital's location. Failure to ensure that hospital policies accurately identify the hospital's location risks staff inability to effectively implement the policy. Findings included: • Record review of the hospital policy titled, "Authorization to Disclose Patient Information," effective 05/17, showed that the hospital was to follow specific requirements for the state of Georgia regarding the release of patient information. The hospital policy did not address specifics of the location of the hospital. • On 03/13/18 at 4:15 PM, ,The Director of Health Information Management (Staff #203) provided the policy to Surveyor #2 and confirmed via interview that the policy governed disclosure of patient information.	E 033	**Plan of Correction for Each specific deficiency Cited:** (E 033) The Hospital failed to update the policy to accurately reflect the location of the facility. **Procedure/process for implementing the plan of correction:** • The policies were updated to local and state requirements this included updating location. • SPBH is currently enrolling in WATrac which will include agreements of transfer during emergency operations. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Details of WATrac and policy updates will be communicated through the safety committee. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice** • The MOUs and policies will be reviewed post Emergency management drills. • Any revisions or recommendations will be presented to the Safety/EOC committee then to the PI committee.	May 23,2018
E 034	Information on Occupancy/Needs	E 034	**Individual Responsible:** Plant Operations Manager	

	CFR(s): 482.15(c)(7)		**Date Completed:** May 23, 2018	

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E 034	Continued From page 11 [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to ensure that the emergency preparedness communication plan contained information on notifying the authority having jurisdiction (AHJ) regarding the hospital's occupancy and ability to provide assistance. Failure to ensure that the emergency preparedness communication plan contained information on notifying the AHJ regarding the hospital's occupancy and ability to provide assistance risks injury or death during an	E 034	**Plan of Correction for Each specific deficiency Cited:** (E034) The Hospital failed to update policies for current facility. **Procedure/process for implementing the plan of correction:** • Policy will be updated to current location. This up to date on local and state codes. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Policies will be reviewed annually. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • Policies will be reviewed for accuracy during post emergency management drills. • Any revisions or recommendations will be presented to the Safety/EOC committee then to the PI committee. • The policy will also address that as not being a Med-surge hospital we do not qualify as the ability to provide assistance for patients with acute medical needs. We will as part of	May 23,2018

			WATrac update our occupancy bed availability for behavioral health patients including ability to provide assistance and needs of facility to continue to provide care and services. **Individual Responsible:** Plant Operations Manager **Date Completed:** May 23, 2018	

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E 034	Continued From page 12 emergency. Findings included: 1. Record review of the hospital document titled, "Emergency Operation Plan," showed that the hospital did not include information in its communication plan regarding disclosing occupancy or ability to provide assistance to the AHJ. The plan does contain a section regrading communication with the AHJ, but it only mentions notifying the AHJ to help facilitate a response and ensure operations continue. 2. On 03/13/18 from 10:00 to 11:20 AM, Surveyor #2 interviewed the Director of Plant Operations (Staff #201) and the Maintenance Technician (Staff #202) on notification of the AHJ regarding occupancy needs and the ability to provide assistance. The director confirmed that this information was not in the plan and stated the county emergency management program would be the AHJ.	E 034		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by:	A 043	**Plan of Correction for Each specific deficiency Cited:** (A 043) The Governing Board failed to provide effective oversight of the hospital and substandard practices. • Under 42 CFR 482.12 Conditions of Participation for Governing Body, 42 CFR 482.13 Condition of Participation for Patient's Rights, 42 CFR 482.21 Condition of Participation for Quality Assessment and Performance Improvement, 42 CFR 482.22 Condition of Participation for Medical Staff, and 42 CFR 482.23 Condition of Participation for Nursing Services **Procedure/process for implementing the plan of correction:** • Beginning April 19, 2018 US Healthvest are requesting that the PI Directors be in attendance at the GB meeting and give a short summary of PI issues being worked on. • PI Committee including the PI dashboard will be presented to Medical Executive Committee then	May 23,2018

			reported to the Governing Board on a quarterly basis. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • PI committee will present to the Medical Executive Committee a report which will then be communicated and sent to the Governing Board on a quarterly basis. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • PI data and reports will be presented to the Governing Board after review in the Medical Executive Committee. This will include minutes and recommendations to the board. **Individual Responsible:** Ryan Robertson, Director of PI and Risk **Date Completed:** May 23, 2018	

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A 043	Continued From page 13 Based on observation, document review and interview, the hospital's governing body failed to provide effective oversight of the hospital . Failure to provide effective oversight to prevent substandard practices for quality improvement, patient safety, management of the medical staff and nursing services resulted in an unsafe environment for patients. Findings included: Due to the scope and severity of deficiencies detailed under 42 CFR 482.12 Conditions of Participation for Governing Body, 42 CFR 482.13 Condition of Participation for Patient's Rights, 42 CFR 482.21 Condition of Participation for Quality Assessment and Performance Improvement, 42 CFR 482.22 Condition of Participation for Medical Staff, and 42 CFR 482.23 Condition of Participation for Nursing Services, the Condition of Participation for Governing Body was NOT MET. Cross Reference: Tags A0046, A0048, A0049, A0067, A0068, A0115, A0263, A0338, and A0385	A 043		
A 046	MEDICAL STAFF - APPOINTMENTS CFR(s): 482.12(a)(2) [The governing body must] appoint members of the medical staff after considering the recommendations of the existing members of the medical staff. This STANDARD is not met as evidenced by:	A 046		

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A 046	Continued From page 14 Based on interview and record review, the hospital failed to ensure that medical staff credentialing followed the Medical Staff Bylaws for appointment of practitioners. Failure to ensure that the hospital follows the Medical Staff Bylaws for the appointment process of providers puts patients at risk of substandard care and adverse outcomes. Findings included: 1. Document review of the hospital document titled, "Medical Staff Bylaws Smokey Point Behavioral Hospital," showed that in article 3.4, Terms of Appointment and Reappointment, initial and reappointments to the Medical Staff shall be made by the Board upon a recommendation from the MEC (Medical Exective Committee). Document review of the hospital document titled, "Governing Board Bylaws," approved on 04/17 showed that the Governing Board selects and appoints the CEO (Chief Executive Officer) who is accountable to the governing board for the recruitment of medical staff and the compliance with the Medical Staff Bylaws. Document review of the hospital's Governing Board Meeting Minutes dated 01/17/18, under the section titled, "Newly Credentialed Staff", showed the name of a physician, Susan Clark, MD. Document review of the hospital's "Application Verfifciation Worksheet 3.24.17" for the physician named above showed that there was no signature documenting review by the credentials committee, no checks indicating approval for appointment or requested privileges and there	A 046	**Plan of Correction for Each specific deficiency Cited:** (A 046) The Hospital failed to: • Ensure that medical staff credentialing followed the Medical Staff Bylaws for appointment of practitioners. • Follow the Medical Staff Bylaws for the appointment process of providers puts patients at risk of substandard care and adverse outcomes. **Procedure/process for implementing the plan of correction:** • Credentialing coordinator will review all of the credentialing immediately report to the CEO and Medical director any credentials and privileges for accuracy and approval. Including one Susan Clark, MD. • CEO and Medical Executive committee will immediately review and approve any credentials and privileges needing amending. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The credentialing coordinator created a tickler system spreadsheet to keep track of upcoming credential renewals. This will be reviewed and monitored monthly. • The credentialing coordinator will notify the CEO. • The CEO will submit a short summary report to the PI Committee. **Process improvement: Address process**	May 23,2018

			improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice: Review of the tickler system monthly by the credentialing coordinator will ensure that all provider files are up to date. **Individual Responsible:** Matt Crockett, CEO **Date Completed:** May 23, 2018	

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A 046	Continued From page 15 was no signature on the signature line for the Medical Executive Committee Chairperson. 2. On 03/15/18 between 10:00 and 11:30 AM, the survey team interviewed members of the governing board. Surveyor #4 asked the governing board about the credentialing process and the lack of evidence for a functional Medical Executive Committee. The corporate Senior Vice President of Clinical Services (Staff #408) stated that the process needed "tightening up".	A 046		
A 048	MEDICAL STAFF - BYLAWS AND RULES CFR(s): 482.12(a)(4) [The governing body must] approve medical staff bylaws and other medical staff rules and regulations. This STANDARD is not met as evidenced by: Based on interview and review of Medical Staff Bylaws, and Medical Staff Rules and Regulations, the hospital's governing body failed to ensure that the hospital's medical staff structure allowed it to carry out its functions consistent with the rules, regulations and bylaws approved by the governing body. Failure to adequately staff and structure the medical staff consistent with the policies and procedures approved by the governing body in the Medical Staff Bylaws, puts patients at risk of substandard care and adverse outcomes. Findings included:	A 048	**Plan of Correction for Each specific deficiency Cited:** (A 048) The Hospital failed to assign committee members to the Medical executive committee. **Procedure/process for implementing the plan of correction:** • The Medical Executive committee voted on the assignments of the President, Vice-President, and Secretary on 3/29/2018 • The MEC will assign a provider to each committee as per Section 11.3 and 11.4 of the Medical Staff By-laws and have it reflected in the minutes. • Information will be reported to the Governing board at a minimum of quarterly by the MEC. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Meeting minutes will be reported to the governing body at minimum of quarterly. **Process improvement: Address process**	May 23,2018

			improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice: • The Medical Director will ensure that the MEC is scheduled on a regular basis as approved by the MEC. **Individual Responsible:** Medical Director **Date Completed:** May 23, 2018	

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A 048	Continued From page 16 1. Document review of the hospital's document titled," Medical Staff Bylaws Smokey Point Behavioral Hospital," (approved 05/30/17) showed that article 11.2 of the bylaws describes the composition of the Medical Executive Committee (MEC) as having a President, Vice-President, and Secretary-Treasurer, who are all active members of the medical staff, and will also include the Chief Executive Officer as an ex-officio member. The duties of the MEC will include recommending to the board all manner of appointments, reappointments and staff membership, and will also account to the board and to the staff for the overall quality of care rendered to patients. Section 11.3 and 11.4 of the Medical Staff Bylaws showed that the MEC shall assign staff functions to include: Quality Management, Credentials Review, Continuing Education, Bylaws, Rules and Regulations, Treatment Plan and Medical Record Review, Utilization Review, Pharmacy and Therapeutics, Infection Control, Risk Management and Patient Safety, Therapeutic Environment and Safety Function, Grievance Committee, and Practitioner Health. Provisions for staffing of these committee functions shall be either through staff assignment or through the MEC itself. 2. On 03/12/18 at 3:55 PM, Surveyor #4 interviewed the Medical Director about the makeup of the Medical Executive Committee and how it functions at the hospital. She stated that there were not enough physicians to have a medical executive committee. Currently, there are 2 full time physicians including the Medical Director, 1 part-time physician and 1 locums	A 048		

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A 048	Continued From page 17 physician.	A 048		
A 049	MEDICAL STAFF - ACCOUNTABILITY CFR(s): 482.12(a)(5) [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This STANDARD is not met as evidenced by: Based on interview and review of hospital documents, the hospital's governing body failed to ensure that it received periodic evaluations of the medical staff's quality of patient care services. Failure by the governing body to monitor and oversee the quality of medical services provided to the hospital's patient population puts patients at risk of substandard care and adverse outcomes. Findings included: 1. Document review of the hospital's Medical Staff (Provider staff) meeting minutes for 05/30/17, 11/08/17, 11/17/17, 12/14/17, 01/17/18 and 01/31/18 showed that meeting minutes contained outlines of discussion topics, but failed to include committee decisions for each topic, action items for completion including assignments, and successive minutes contained no follow-up information from items put forward from the previous meeting. Document review of the Governing Board Meeting minutes for 01/17/18 (The only minutes provided to the surveyors by the hospital) showed	A 049	**Plan of Correction for Each specific deficiency Cited:** (A 049) The Hospital failed to ensure that a privileged physician is on call at all times to provide supervision of mid-level providers and overall patient care puts patients at risk of harm from substandard care. **Procedure/process for implementing the plan of correction:** • Medical Staff Committee minutes will be taken by the credential coordinator. Minutes will include more than the agenda. Additional text, action plans, and discussion of patient care will be included. • PI committee meeting minutes including data will be reported to the Medical Executive committee. • All Medical Staff Committee minutes will be sent to the Governing Board for review and approval. • The On-Call schedule will be developed and maintained including 24-hour physician coverage in order to ensure the provision of supervision to all mid-level practitioners. • The Medical director/designee will be responsible for addressing any last-minute changes or revisions to the on-call schedule. **Monitoring and Tracking procedures to ensure**	May 23,2018

			the plan of correction is effective: • Minutes will be reported to governing board, including but not limited to the 24-hour coverage schedule of physicians providing supervision to mid-level practitioners. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • Minutes and on call schedule for physicians will be reported to the Governing Board. **Individual Responsible:** Dr. Elina Durchman, MD **Date Completed:** May 23, 2018	

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A 049	Continued From page 18 that the following committees submitted meeting minutes to the Board for approval: Infection Control, Environment of Care/Safety, Performance Improvement/Executive Credentials, Medical Staff, Pharmacy and Therapeutics, and Grievance. Medical staff minutes approved by the Board consisted of 6 bulleted items without additional text, or action plans. 2. On 03/15/18 between 10:00 and 11:30 AM, the survey team interviewed the hospital's governing body, including the hospital's Medical Director (Staff #401) about how the governing body receives information about patient safety and the overall operation of the hospital. Members of the governing body stated that their monitoring is multidimensional and includes review of all meeting minutes and that staff members make presentations at various times in the facility. Surveyor #4 asked if the governing body had evidence that the Medical Director directly interacted with the board regarding the medical care of patients. The board members indicated that there were discussions with the Medical Director, but there was no documentation in the minutes to reflect the topics or the scope of those discussions. Cross Reference: Tag A0068, A0338	A 049		
A 067	CARE OF PATIENTS - MD/DO ON CALL CFR(s): 482.12(c)(3) [...the governing body must ensure that the following requirements are met:] A doctor of medicine or osteopathy is on duty or	A 067		

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A 067	Continued From page 19 on call at all times. This STANDARD is not met as evidenced by: Based on document review and interview, the hospital's governing body failed to ensure that a doctor of medicine or osteopathy was on call at all times to provide onsite supervision of patient care . Failure to ensure that a privileged physician is on call at all times to provide supervision of mid-level providers and overall patient care puts patients at risk of harm from substandard care. Findings included: 1. Document review of the hospital's "on-call log" received from the Director of Performance Improvement and Risk (Staff #405)on 03/14/18, showed that from 01/29/18 to 03/31/18, a physician was only listed on call for 12-hour periods (8:00 AM to 8:00 PM) for the following dates: 01/29/18, 01/30/18, 02/05/18, 02/12/18, 02/19/18, 02/24/18, 02/26/18, 03/05/18, 03/12/18, 03/19/18, and 03/24/18. The remaining shifts show either no one listed for coverage, or mid-level providers (Advanced Registered Nurse Practitioner, Physician Assistant). Document review the hospital's "Medical Staff Policies and Procedure," effective date (4/17), showed that each month, the Medical Director will assure that a schedule identifying the psychiatrists and on-call dates is completed and distributed to all appropriate personnel. 2. On 03/15/18, between 10:00 and 11:30 AM, the surveyors interviewed the hospital's governing	A 067	**Plan of Correction for Each specific deficiency Cited:** (A 067) The Hospital policy titled assessment of patients failed to address information about the patient's physical health status which might affect the appropriateness of their admission. **Procedure/process for implementing the plan of correction:** • A new calendar will be created to include 24 hour coverage of the physician on call. • Policy will be revised to state that a physician is available 24 hours a day as demonstrated by the on call calendar. • All admission requests for patients with medical issues will be reviewed with the admitting practitioner. • Should the admitting practitioner be a mid-level practitioner and the admission staff have a concern that the case needs further review the physician on call will be provided the information to ensure that the facility has the capability of handling the medical acuity of the patient. • Should there remain further concerns the medical director will be contacted for final approval. • There is always an internal medicine practitioner that can also be contacted for consultation, if the need arises. • Any decision that was made contrary to the initial provider's order will be addressed, to explain why the patient	May 23,2018

was or was not accepted.
- If questions about admitting procedures following the admission criteria of the hospital exists, the case will be referred for FPPE/OPPE review.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- The CEO is notified of all patient admissions requests that are declined, in order to ensure that all EMTALA procedures have been complied with.
- The Medical Staff will conduct OPPE/FPPE accordingly..
- The on-call schedule is updated monthly for the medical director.
- Monitoring will include that the monthly physician calendar has a physician assigned for every day on call. This will be audited.. The number of days a physician is marked on call in the monthly schedule over the number of days in the month. This will be reported at the Medical Executive meeting. 100% compliance target. If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month than spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported to the Director responsible for the identified item.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- The Medical Staff conduct OPPE/FPPE review on cases that there are questionable admissions of not following admission

			criteria. • The UM Committee reviews cases of questionable medical necessity. **Individual Responsible: Medical Director** **Date Completed:** May 23, 2018	

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A 067	Continued From page 20 body. During the interview, Surveyor #4 asked the Medical Director (Staff #401) about how the hospital ensured there was 24- hour coverage of patients by a physician, when the call log did not reflect that staffing. She stated that she is always available, but there was no documentation or policy that described that process.	A 067		
A 068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE CFR(s): 482.12(c)(4) [...the governing body must ensure that the following requirements are met:] A doctor of medicine or osteopathy is responsible for the care of each Medicare patient with respect to any medical or psychiatric problem that-- (i) Is present on admission or develops during hospitalization; and (ii) Is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor; or clinical psychologist, as that scope is-- (A) Defined by the medical staff; (B) Permitted by State law; and (C) Limited, under paragraph (c)(1)(v) of this section, with respect to chiropractors. This STANDARD is not met as evidenced by: Based on interview, record review, and review of hospital policies and procedures the Governing Body failed to develop and maintain effective systems that ensured that patients received quality healthcare that met their needs in a safe environment. Failure to ensure patients are provided with care	A 068	**Plan of Correction for Each specific deficiency Cited:** (A 068) The Hospital failed to receive quality healthcare that met the patient's needs. **Procedure/process for implementing the plan of correction:** 1. CNO will re-train all nurses to review all possible sources of information regarding patient allergies, including: • Pre-hospital records • Patient interview • Family/friend interview • Any known pharmacy records • History & physical (if available) • Treatment team members • CNO will re-train all nurses on medical issues identified during the survey by written documentation and post tests which includes but not limited to. • Paralyzed patient care • Catheterization	May 23,2018

- Urinary Tract Infections
- Anaphylactic Allergies
- Diabetic care
- Wound Care

- All admission requests for patients with medical issues will be reviewed with the admitting practitioner.
- The facility will comply with its own admitting criteria from the admission, discharge and continued stay criteria policy and procedure. Included in this is the statement "The above may be waived, where appropriate only by the admitting attending physician with approval by the Medical Director." The Medical Director is always the final say in patient care.
- Should the admitting practitioner be a mid-level practitioner and the admission staff have a concern that the case needs further review the physician on call will be provided the information to ensure that the facility has the capability of handling the medical acuity of the patient.
- Should there remain further concerns the medical director will be contacted for final approval.
- There is always an internal medicine practitioner that can also be contacted for consultation, if the need arises.
- Any decision that was made contrary to the initial provider's order will be addressed, to explain why the patient was or was not accepted.
- Review of denials or questionable admissions will be reviewed in the Medstaff meeting and then reported to Medical executive committee.
- If questions about admitting procedures following the admission criteria of the hospital exists, the case will be referred for FPPE/OPPE review.

- RNs & MHTs were retrained on the inventory of Central Supply. (Catheters have always been available in Central Supply)
- . CNO published in the nursing newsletter that it is common for paraplegic patients to self-catheterize and to use the same catheter repeatedly, as long as proper Infection Control procedures are followed.
- Staff were reminded to order dietitian consults at the time of the nursing admission assessment, if warranted. Since then, daily chart audits have been conducted and this area is examined for accuracy. Any adverse findings have resulted in A) the dietitian being immediately consulted and B) the employee being counseled.
- By April 23, the CNO will have established a business relationship with a wound care clinic or consultant. The hospital will either transport patients in need of wound assessments to that clinic/consultant or have the clinic/consultant come to the hospital for consult. Medical & Nursing Staff will be educated on the new process. Additionally, the CNO will remind Intake personnel of our exclusionary criteria related to known wounds at the time of screening potential admissions.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Monitoring of the Nursing Assessment is occurring by the CNO/designee. All issues identified are being addressed immediately.
- 15% of the medical records will be audited five times a week. Auditing will continue until 100% compliance for one month. If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month than spot checks of 2 medical records at a minimum will be reviewed for the items monthly. Identified issues will be reported to

			the CNO. • Questionable admissions and denials will be reviewed in the medstaff meeting and then reported in the Medical Executive Committee as well as review in OPPE/FPPE. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** Monitoring is reported in audit meetings and will continue to be addressed in PI Committee meetings. **Individual Responsible:** John Beall, CNO **Date Completed:** May 23, 2018	

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SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

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that meets acceptable standards of practice and meets the patient's healthcare needs in a safe environment risks deterioration of the patient's condition and poor healthcare outcomes.

Findings included:

1. Document review of the hospital's policy titled, "Assessment of Patients," (effective 05/17) showed that at intake, the hospital obtains information on the caller's current condition, the type of services they are seeking, who referred the patient, and appropriate disposition. The policy does not address information about the patient's physical health status, which might affect the appropriateness of their admission.

Document review of the hospital's policy titled, "Medical Staff Rules and Regulations" (Effective 04/17) showed that in Chapter 3, Criteria for Admission, all admissions shall meet the inclusion criteria as established by the medical staff and that admissions shall be on the order of a physician on the Medical Staff.

2. On 03/08/18 at 1:00 PM, Surveyor #5 interviewed a Physician Assistant (Staff #519) about patients admitted to the hospital. Staff #519 stated that medically unstable patients have been denied admission by the medical provider, based on the hospital's exclusion criteria, only to have the denial superceded. He stated that patients were denied admission and then showed up on the unit the next day.

3. On 03/15/18, between 10:00 and 11:30 AM, the surveyors interviewed the hospital's governing body about admission of patients with complex medical needs. The Chief Nursing Officer (Staff

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A 068	Continued From page 22 #407) stated that he receives calls "a couple of times a week" from intake staff regarding appropriateness (of admission). He stated that if he does not feel confident, then he speaks with the Chief Executive Officer (Staff #410). If he approves, they go forward with screening. Patient #525 4. On 03/09/18 at 8:30 AM, Surveyor #5 reviewed the discharged medical record for Patient #525 who was admitted on 01/24/18 for the treatment of suicidal ideation that included a plan to kill himself. The medical record review showed: The Emergency Department provider notes dated 01/23/18 at 5:51 PM showed that the patient's medical history included: -Spina bifida (a spinal birth defect) -A neurogenic bladder (dysfunction of the urinary bladder due to disease of the central nervous system or peripheral nerves involved in the control of urination) -An elevated white blood cell count -A urinary tract infection -Wheelchair bound -Has an anaphylactic allergy to peanuts On 01/24/18 at 8:00 PM, a provider wrote admitting orders. Allergies were documented as "NKDA" (no known drug allergies). On 01/25/18 at 7:00 AM, the Admission Medical History and Physical Examination showed that that the patient had an allergy to peanuts, spina bifida, neurogenic bladder, a urinary tract infection, and an activity restriction of	A 068		

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"wheelchair." Current genitourinary concerns showed that the patient catheterized himself with a Coude catheter and that he had weakness in his lower extremities. The physical assessment showed that the patient had swollen legs with atrophy related to the Spina Bifida and decreased strength in the lower extremities.

Between 01/26/18 and 02/01/18, Surveyor #5 found no evidence that the provider wrote orders for the management of the patient's urinary concerns, including the need for a supply of catheterization equipment or for a bowel program related to the patient's Spina Bifida and neurogenic bladder diagnosis.

On 02/02/18, the provider wrote the following order: "Straight cath (catheterization) 4-6 times daily as needed for neurogenic bladder. May use own supply until pharmacy can provide appropriate cath."

On 02/05/18 at 8:00 PM, a nursing document showed that a supply of straight catheter equipment was obtained for the patient, 12 days after admission.

On 03/08/18 at 1:00 PM, Surveyor #5 interviewed a provider (Staff #519) about Patient #525. During the interview, Staff #519 stated that hospital staff had removed the patient's catheter from his room and thrown it away in the biohazard trash. Staff from another shift took it out of the trash, washed it, and returned it to the patient.

On 02/01/18 at 10:15 AM, a Psychiatric progress note showed that the patient had ingested a nutrition bar containing nuts. Hospital staff administered two Epinephrine Pens and 50mg of

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Benadryl to the patient to control the anaphylactic response. The note also stated, "Emergency Department was called and patient was prepared for transport. Medical Director canceled transport and consulted medical." A change was entered on to the Admission provider orders where allergies had been previously documented as "NKDA" (no known drug allergies). A line was crossed through the word "NKDA" and "Peanuts Error 2/1/18 11:30 am" was written next to the entry.

On 02/01/18 at 11:00 AM, a progress note showed that the patient selected a snack at snack time and had taken a bite of it. A Physician Assistant assessed the patient and documented that the patient was having symptoms of anaphylaxis. The provider administered Epinephrine via an Epi-Pen injector. A second Physician Assistant assessed the patient and the patient received a second Epi-Pen injection. The documentation showed that the ambulance arrived, but that a Physician (Staff #515) called and "stated not to transport patient to the Emergency Room, monitor in the facility for complications."

On 03/06/18 at 9:00 AM, Surveyor #11 and a provider (Staff #514) discussed the provider's concerns about the quality of care provided for Patient #525. The provider stated that she was concerned because the patient had received 2 doses of Epinephrine and the patient was not transported to an Emergency Room for further evaluation following the incident.

On 03/08/18 at 1:00 PM, Surveyor #5 interviewed (Staff #519) about Patient #525. During the interview, Staff #519 stated that he ordered the

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A 068	Continued From page 25 patient to be transferred to an Emergency Department because the patient had received two doses of epinephrine, the hospital had no airways and no way to start an intravenous line and he felt the patient needed to be monitored closely. He stated he had written twice for the patient to be transported to the Emergency Department for evaluation but that the Medical Director had overridden the order. Patient #504 5. On 03/12/18, Surveyor #5 reviewed the medical record of Patient #504 who was admitted on 02/06/18 for treatment of Psychosis, Suicidal Ideation, Command Auditory Hallucinations to harm self, Audio, Visual and Tactile Hallucinations, poor sleep and poor appetite. The medical record review showed the patient was a diabetic and taking metformin (a medication used to treat patients with Type 2 Diabetes). The patient nutritional screen on admission showed the patient is a Diabetic, which required the patient to receive a referral for a Nutritional consult. Surveyor #5 found no evidence the patient was referred or received a Nutritional consult. On 02/10/18 at 1:30 PM, a provider wrote an order for a medical referral because the patient had been taking metformin as an outpatient. Surveyor #5 found no evidence the patient received a medical referral for her diabetes/diabetes medication. The patient medication administration record showed that the patient did not receive metformin during her hospitalization. Patient #1101	A 068		

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A 068	Continued From page 26 6. On 01/26/18 at 11:00 PM, Patient #1101 was readmitted to the psychiatric hospital for psychiatric care following discharge from a medical center where the patient received care for cellulitis and diabetic ulcers on the right great toe and 2nd toe. Review of the patient's discharged medical record showed the following: On 01/27/18 at 8:30 AM, a medical consultant (Staff #1105) completed the patient's history and physical. The history and physical examination showed that the patient had cellulitis and a diabetic foot ulcer. The medical consultant referred the patient for wound care and stated that the patient was medically stable for psychiatric treatment unless the wound worsens. The physician's order in the patient's medical record showed the medical consultant (Staff #1105) wrote an order on 01/27/18 at 8:40 AM referring the patient to a wound care clinic as soon as possible, to evaluate and treat the wound. The medical consultant's documentation dated 01/30/18 at 8:30 PM showed that the patient's diabetic foot ulcer was worsening. The medical consultant again recommended the hospital staff consult wound care. The medical consultant's documentation dated 02/02/18 at 8:45 AM showed that the patient had an open wound on the second toe of the right foot. The consultant stated that the toe needed debridement (removal of damaged tissue) and the hospital staff should follow through with the wound care referral.	A 068		

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There was no evidence in the medical record to show that the hospital had referred the patient to a wound care clinic for treatment of the diabetic ulcers.

Document review of the form titled, "Memorandum of Transfer," showed the hospital transferred Patient #1101 to a medical center on 02/05/18 at 2:55 PM for treatment of the diabetic foot ulcers.

On 03/07/18 at 5:00 PM, Surveyor #11 interviewed a registered nurse (Staff #1101) about the referral to the wound care clinic for Patient #1101. The registered nurse confirmed that the hospital did not send the patient to a wound care clinic.

On 03/09/18 at 10:00 AM, Surveyor #11 reviewed the patient's medical record with the Chief Nursing Officer (Staff #1102). The Chief Nursing Officer confirmed that there was no documentation in the patient's medical record indicating that the hospital referred the patient to a wound care clinic. When the surveyor asked Staff #1102 about Patient #1101's missed medical referral, the Chief Nursing Officer stated that the registered nurse that transcribed the order was responsible for making the referral.

On 03/13/18 at 3:15 PM, the Discharge Summary completed by the provider (Staff #1106) showed that the hospital transferred Patient #1101 to the emergency department at the medical center for treatment of worsening toe infection and worsening levels of pain.

On 03/14/18 at 11:15 AM, Surveyor #11 interviewed a registered nurse (Staff #1103)

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A 068	Continued From page 28 about the process for referring Patient #1101 to the wound clinic. The registered nurse stated that at the time the order was noted by Staff #1103, a medical consultant (Staff #1105) and a nurse practitioner (Staff #1104) were there discussing the patient. The nurse stated that he thought the Nurse Practitioner would refer the patient to the wound clinic. The nurse found out later that referrals like this should be brought to the attention of the nurse manager. Staff #1103 stated that he has not received training on the hospital's process for referring patients to outside facilities. Cross Reference: Tag 0396	A 068		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to protect and promote patients' rights related to personal privacy, care in a safe setting, and restraint use, Failure to protect and promote each patient's rights risked the patient's loss of personal freedom, dignity, physical and psychological harm. The cumulative effects of these systemic problems resulted in the hospital's inability to provide for patient and staff safety, resulting in the surveyors' declaration of two immediate jeopardy situations.	A 115	**Plan of Correction for Each specific deficiency Cited:** (A 115-1) The facility did not develop and implement a system to ensure the safety of patient identified as being a danger to self or others. This posed a serious risk of harm due to: • No adequate system for communicating a patient's line of sight status to ward staff. • Staff unaware of Line of Sight status despite a provider order for Line of Sight in a patient's file. • Ward staff describing inadequate staffing to achieve line of sight monitoring.	March 8,2018

- The facility-provided list of patients on the "Line of Sight" list did not contain 2 patients with orders, identified during the survey.

Procedure/process for implementing the plan of correction:

All nursing staff were re-trained on Line of Sight policies and procedures, and danger to self and/or others treatment planning, by March 8, 2018. In order to demonstrate competency each nursing staff was tested, with competency documentation placed in the employees HR file.

Nurses are ensure the process' was conducted appropriately respecting the patient's dignity and right to privacy, but also protecting the patient's safety.

White boards are being audited by the Nurse Managers to ensure the accuracy of all special precautions are being listed accurately If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month than spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported to the CNO.

Special precautions are communicated during shift report.

The nursing report sheet is now being used to maintain an accurate list of precautions for each patient.

The medical record will correlate by having in the master treatment plan the specific precautions the individual is on and interventions necessary to protect the individual from harm.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

Nurse Managers will audit the boards daily and ensure that all information including special precautions is accurate. This will be audited with a 100% compliance rating continuously for three months. If compliance

goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month than spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported to the CNO.

15% of randomly selected medical records will be audited five times a week by nursing to conduct chart audits and report in a daily meeting. Auditing will continue for 100% compliance for three months. If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month than spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported to the CNO.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

March 8,2018

The Chief Nursing Officer will receive a daily written report of all orders for Line of Sight which will be tracked in a log with date order written and date of order discontinued. This will be reviewed daily by the Nurse Manager/designee will ensure all active Line of Sights are logged and are being adhered to. The Chief Nursing Officer will report data at the monthly Performance Improvement meeting for compliance.

Individual Responsible:
John Beall, RN, CNO
Date Completed:
3/8/2018

Plan of Correction for Each specific deficiency Cited:

(A 115-2) The facility did not ensure that suicidal patients received care in a safe setting. This posed a serious risk of harm due to:

- Failure to provide adequate monitoring of patients admitted for suicidal ideation or assessed at risk for suicide in order to prevent future attempts.
- Failure to notify the patient's provider following a suicide attempt.
- Failure to increase monitoring following a suicide attempt.
- Failure to develop and implement a policy that provides clear direction for staff for monitoring of patients who have expressed suicide ideation or made suicide attempts.

Procedure/process for implementing the plan of correction:

The Chief Nursing Officer immediately corrected the suicide risk of harm finding by:

- The "Precaution: Suicide" policy was revised to delineate line of sight, Q 5 minute, and 1:1 observation categories. The revised policy provides instruction to staff to immediately notify the physician/provider for HIGH or SEVERE risk of suicide (at time of assessment) and any suicide gestures or suicide attempts. Further, the policy instructs staff to notify the CEO for any suicide attempts. The policy provides that the minimum level of observation for a patient on suicide precautions is "every five minutes." Based on assessment criteria and a conversation with the provider, this level of observation may be increased to "line of sight" or "1:1" level. The observation is based on the specific information related to the identified concern, in addition to general suicidal precautions. This information is to be handed off to all staff conducting monitoring of this patient.
- The "Precaution: Suicide" policy was

revised to instruct the nurse to document in the medical record the event, the actions taken by the nursing staff, the response of the patient, the notification of the practitioner and orders received and the institution of actions taken in response to the orders taken. Documentation also must include all others notified of the event, including CEO, CNO, Nursing Supervisor, family members, and all others notified.

- The "Precaution: Suicide" policy was revised to include that an incident report will be completed by the staff member documenting any suspected suicide attempt.
- The Suicide Risk Assessment was revised to include notification to the CNO for patients at HIGH or SEVERE risk of suicide upon admission to the facility.
- The admission orders were changed to reflect three possible choices for patients at risk of suicide: Q 5 minutes, Line of Sight, or 1:1.
- A separate order sheet template was created for use later during a patient's stay should he/she become suicidal.

The Medical Director trained the practitioners to verbally inform nurse of new orders and flag the new orders. This occurred by March 8,2018.

The CNO retrained the nurses to:

- Immediately notify the physician/provider of any observed or reported suicide gesture or attempt.
- Notify the CEO of any suicide attempts.
- Immediately increase the level of observation for any patient who attempts suicide while in the hospital & then notify the physician/provider.
- Update the patient's treatment plan to reflect the need for the increased level of observation, and
- Notify their Nurse Manager and/or the staffing coordinator of the new order so that an assessment may be made to

allocate proper staffing resources.
This education occurred by March 8,2018
All nursing staff will be re-trained on Suicide policies and procedures, and danger to self and/or others treatment planning, by March 8, 2018. In order to demonstrate competency each nursing staff was also tested, and documentation of competency was placed in the employees HR file.
White boards will be audited by Nurse Managers to ensure accuracy of suicide precautions are listed and accurate.
Nurses are to ensure the process' were conducted appropriately respecting the patient's dignity and right to privacy, but also protecting the patient's safety.
Nursing will be re-educated documentation supporting that the interventions carried out were performed and the patient response will be documented.
Suicide precautions will be communicated during shift report.
The nursing report sheet will be used to maintain an accurate list of precautions for each client.

Monitoring and Tracking procedures to ensure the plan of correction is effective:
Nurse Managers will audit the white boards daily and ensure that all information including special precautions is accurate. This will be audited with a 100% compliance rating continuously for three months. If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month than spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported to the CNO.

15% of the medical records will be audited five times a week by nursing. Auditing will continue for 100% compliance for three months. If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance

			is reached for 1 continuous month than spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported to the CNO. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • Nurse Managers will audit the white boards daily and ensure that all information including special precautions is accurate. This will be audited with a 100% compliance rating continuously for three months. • The Chief Nursing Officer will receive a daily written report of all orders for Suicide Precautions which will be tracked in a log with date order written and date of order discontinued. This will be reviewed daily by the Nurse Manager will ensure all active Suicide Precautions are being carried out. The Chief Nursing Officer will report out at monthly Performance Improvement meeting for compliance. **Individual Responsible:** John Beall, RN,CNO **Date Completed:** 03/08/2018 **Plan of Correction for Each specific deficiency Cited:** (A 115-3) The Hospital failed to provide the important message about your Medicare rights to patients upon admission and 48 hours prior to discharge. **Procedure/process for implementing the plan of correction:** Nursing and Discharge planning	May 23, 2018 5/23//2018

			have been reeducated on the proper protocol and have implemented this process no later than May 23, 2018. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** 15% of medical records will be audited 5 days a week by a selected team of auditors to review charts to ensure this practice (IMM) is incorporated in to standard routine. Education will be provided to any staff found not in compliance by the Director of Clinical Services or CNO with this process. The audit will continue until 100% compliance in a month is reached. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** The Director of Utilization Management will report the audit compliance to the Performance Improvement committee on a monthly basis until 100% compliance is reached for 1 month. **Individual Responsible:** Director of UM **Date Completed: May 23**, 2018 **Plan of Correction for Each specific deficiency Cited:** (A 115-4) The Hospital failed to provide an acknowledgement and resolution letter to grievances that are applicable to State and CFR crosswalk. **Procedure/process for implementing the plan of correction:** The Patient Advocate will respond to all grievances with an acknowledgement and resolution letter to the individual according to CMS and State regulations. Copies of the letter will be logged with the grievance.	May 23, 2018

Monitoring and Tracking procedures to ensure the plan of correction is effective:
Grievance, acknowledgement, and resolution letter will be available during the grievance committee meetings to review.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:
Data will be sent to the PI committee in regard to letters with completed forms for review from the grievance committee.
The PI Committee forwards a summary of the grievances, including the contents of the letter and resolution of the grievance to the Governing Board.

Individual Responsible:
Ryan Robertson
PI and Risk Director
Date Completed:
3/28/2018

Plan of Correction for Each specific deficiency Cited:
(A 115-5) The Hospital failed to protect vulnerable patients from abuse.

Procedure/process for implementing the plan of correction:

- The Chief Nursing Officer will re-educate staff on definitions and procedures adhering to close observations and the meaning of each.
- All staff will be re-educated on proper procedures for reporting incidents.
- Nurses will be educated by written documentation and post test ensuring the process' were conducted appropriately respecting the patient's

dignity and right to privacy, but also protecting the patient's safety.

- Nursing Staff have be re-educated on skin checks. Skin checks will not be conducted in the quiet room where patients are in view of cameras for the process.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Nursing staff have received the re-education on the prevention of abuse including policies.
- Nursing Supervisors will report any incidents for their shift to the Chief Nursing Officer by the end of their shift.
- Nursing Supervisors will ensure all incident reports are filed prior to the end of the shift.
- The CNO will review all incidents the next business day.
- Incidents will be reported in the daily huddle by PI Director of Designee.
- The incident reports will be delivered to the appropriate director for follow up in their department.
- Incidents will then be returned to the PI director for determination of any further actions and filed.
- Incidents that reach the current state standards for an adverse event or Joint Commission's sentinel event will be reported to senior leadership for final determination immediately upon review of the incident reports the next day, by the PI director or CEO.
- Root Cause Analysis will be conducted on all incidents designated as Sentinel Events.

5/23/2018

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient

			practice: • All events will be aggregated and reported on the monthly basis to the Performance Improvement Committee. • Security footage from the S/R rooms will be reviewed from the previous day or weekend on Monday's to ensure that no skin checks have been conducted inappropriately. Auditing will be number of patients admitted in the month that had skin checks not done in the S/R room over the number of admits. This will be reviewed until 100% compliance is reached for one continuous month with findings reported to the PI committee. If compliance goes below the threshold of 95% for 1 month a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month than spot checks will be conducted on a monthly. Identified issues will be reported to the CNO. • Nursing will be tested on the re-education of prevention of abuse and policies. The test will be placed in the staff's HR file. Any wrong answers will be reviewed by the proctor with the staff member immediately for correction. **Individual Responsible:** Ryan Robertson, PI and Risk Director **Date Completed:** May 23, 2018 **Plan of Correction for Each specific deficiency Cited:** (A 115-6) The Hospital failed to monitor the patient in restraints or seclusion as directed by hospital policy and procedure. **Procedure/process for implementing the plan of correction:** • Nursing was re-educated on proper policy and procedure as to	May 23, 2018

documentation and observations for patients in restraint or seclusion.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Nursing will report all seclusion and restraint events to the CNO including all documentation via to CNO's email by scanning the completed documentation and emailing it directly to CNO.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- CNO will review S/R documentation for accuracy and observations. Any non-compliance will be followed up by nurse management, and reported back CNO. Information will be reported to PI committee by CNO on a monthly basis.

March 16, 2018

Individual Responsible:
John Beall, CNO

Date Completed:
May 23, 2018

Plan of Correction for Each specific deficiency Cited:
(A 115-7) The Hospital failed to get physician's order for the patient in restraints or seclusion as directed by hospital policy and procedure.

Procedure/process for implementing the plan of correction:

- Nursing was re-educated on proper policy and procedure as to documentation and observations for

patients in restraint or seclusion.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Nursing will report all seclusion and restraint events to the CNO including all documentation via to CNO's email by scanning the completed documentation and emailing it directly to CNO.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- CNO will review S/R documentation for accuracy and observations. Any non-compliance will be followed up by nurse management, and reported back CNO. Information will be reported to PI committee by CNO on a monthly basis.

Individual Responsible:
John Beall, CNO

Date Completed:
May 23, 2018

Plan of Correction for Each specific deficiency Cited:
(A 115-8) The Hospital failed to provide privacy for skin checks during the admission process.

Procedure/process for implementing the plan of correction:

- Nursing Staff have be re-educated on skin checks. Skin checks will not be conducted in the quiet room where patients are in view of cameras for the process.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Nursing supervisors will report to the Chief Nursing officer (CNO) of all

admits and locations that skin checks were performed.
- Nurses will provide an incident report of any skin checks not done privately.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Nursing Department will report the number of non-private skin checks conducted to the Performance Improvement committee on the monthly basis.

Individual Responsible:
John Beall, Chief Nursing Officer
Date Completed:
March 16, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	C 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 115	Continued From page 29 Findings included 1. On 03/05/18 at 4:30 PM and on 03/06/18 at 4:45 PM, the surveyors notified hospital administrators that immediate jeopardy situations existed due the hospitals failure to provide a safe care environment for patients identified as a danger to self and others. 2. On 03/06/18 at 4:45 PM, the surveyors notified hospital administrators that that immediate jeopardy situations existed due the hospitals failure to provide a safe care environment for patients identified at risk for suicide. 3. The hospital failed to notify patients of their rights. 4. The hospital failed to provide written notice of outcome of grievance investigation. 5. The hospital failed to protect vulnerable patients from abuse. 6. The hospital failed to monitor the patient in restraints or seclusion as directed by hospital policies and procedures. 7. The hospital failed to provide a signed physician's order for continued restraint use. 8. The hospital failed to provide personal privacy. Due to the scope and severity of deficiencies cited under 42 CFR 482.13, the Condition of Participation for Patient Rights was NOT MET. Cross-Reference: Tags A0117, A0123, A0143, A0144, A0166, A0167, A0168	A 115		

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A 115	Continued From page 30	A 115		
A 117	PATIENT RIGHTS: NOTICE OF RIGHTS CFR(s): 482.13(a)(1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. This STANDARD is not met as evidenced by: Based on interview, record review and review of hospital policies and procedures, the hospital failed to ensure that Medicare patients received notification of their right to appeal their discharge to a designated Quality Improvement Organization, as demonstrated by 5 of 5 patients reviewed (Patients #906, #908, #912, #913, and #914). Failure to notify patients of their rights to appeal their discharge leads to infringement on patient rights and possible poor patient outcomes. Reference: 42 CFR 405.1205(b) - "Hospitals must provide each Medicare beneficiary who is an inpatient a standardized notice, the "Important Message from Medicare", within two days of their admission and again within two calendar days before discharge.. . . The hospital must establish and implement policies and procedures that effectively ensure that patients and/or their representatives have the information necessary to exercise their rights." Findings included:	A 117	**Plan of Correction for Each specific deficiency Cited:** (A 117) The Hospital failed to provide the important message about your Medicare rights to patients upon admission and 48 hours prior to discharge. **Procedure/process for implementing the plan of correction:** Nursing and Discharge planning have been educated on the proper protocol and have implemented this process as of May 28,2018 **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • 15% of medical records will be audited on 5 times a week to review charts to ensure this practice is incorporated in to standard routine for the IMM. Education will be provided to any staff found not in compliance with this process. The audit will continue until100% compliance in a month is reached. • Discharge Planners will begin tracking all Medicare patients closely and provide the Important Message from Medicare notification at first opportunity in planning for patient discharge. • Discharge Planners will also provide a copy of the notification given to	May 23,2018

			patients to the Director of Clinical Services and Director of Utilization Management as proof of completion. • The Director of Clinical Services will audit the SPBH Discharge Calendar daily to ensure all Medicare patients listed for discharge within 2 days received the Important Message From Medicare as identified item #2 above. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** The Director of Utilization Management will report the audit compliance to the Performance Improvement committee on a monthly basis until100% compliance is reached for 1 month. If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month than spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported to the Director of UM responsible for the identified item. **Individual Responsible:** Director of UM **Date Completed:** May 23, 2018	

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A 117	Continued From page 31 1. On 03/15/18 at 2:00 PM, the Quality Manager (Staff #901) stated that the hospital did not have a policy regarding when the patients would be given the standardized notice, "Important Message for Medicare" as required with 42 CFR 405.1205 (b). 2. Surveyor #9 reviewed the medical records of five patients who had been discharged prior to the date of the review on 03/14/18. Four of the records reviewed showed that patients (Patients #906, #908, #912, #913) had received the initial "Important Message from Medicare" upon admission but did not receive a second notice prior to discharge. Review of Patient #914's record revealed that the patient received the "Important Message from Medicare" upon admission and again on the day of discharge but not 2 days prior to discharge as required.	A 117		
A 123	PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION CFR(s): 482.13(a)(2)(iii) At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Based on document review and interview, the hospital failed to provide written notification to	A 123	**Plan of Correction for Each specific deficiency Cited:** **(A 123)** The Hospital failed to provide an acknowledgement and resolution letter to grievances that are applicable to State and CFR crosswalk. **Procedure/process for implementing the plan of correction:** The Patient Advocate will respond to all grievances with an acknowledgement and resolution letter to the individual according to CMS and State regulations. Copies of the letter will be logged with the grievance. **Monitoring and Tracking procedures to ensure the plan of correction is effective:**	April 1, 2018

			Grievance, acknowledgement, and resolution letter will be available during the grievance committee meetings to review. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • Data will be sent to the PI committee in regard to letters with completed forms for review from the grievance committee. • Target compliance with acknowledgement and resolution letters is 100%. If compliance goes below the threshold of 90% for 2 months a new corrective action plan will be created to address the finding. **Individual Responsible:** Ryan Robertson PI and Risk Director **Date Completed:** 4/1/2018	

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A 123	Continued From page 32 complainants in response to grievances. Failure of the hospital to provide written notice of the outcome of their grievance investigation, and steps taken on behalf of the patient or the patient's family to investigate the grievance violates their right to be informed of how the hospital investigated and resolved the grievance. Findings included: 1. Document review of the hospital's policy titled, Grievances, The Patient Advocate, and The Grievance Committee," effective date 8/17, showed that written responses to grievances are to be provided within 30 days of the filed grievance. 2. On 03/14/18, between 1:40 and 2:00 PM, Surveyor #4 reviewed the hospital's grievance log. The review showed that between 12/09/18 and 12/10/18, family members of 5 patients (#401, #402, #403, #404, #405) filed 6 grievance reports regarding staff "cutting short" visiting hours with patients. The surveyor found evidence in the log that the Patient Advocate or Grievance Committee had provided a written resolution to the complainants. The only documentation in the log was a hand written note on the back of the last grievance that stated "called all back and have apologized", signed by the Director of Performance Improvement & Risk (Staff #405). 3. At the time of the review, Surveyor #4 asked the Director of Performance Improvement & Risk (Staff #405) why some grievances contained in the grievance log had resolution letters attached and some did not. He stated that he was not consistently providing written notice of the	A 123		

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A 123	Continued From page 33 hospital's grievance decisions but that he documented phone contacts in the log.	A 123	**Plan of Correction for Each specific deficiency Cited:** (A 143) The Hospital failed to provide privacy for skin checks during the admission process. **Procedure/process for implementing the plan of correction:** • Nursing have been re-educated on skin checks. Skin checks will not be conducted in the quiet room where cameras are in view of the patient for the process. This was sent to all staff via email. • On 3/15/2018, the skin check process was changed to be conducted in the patient's room, in private, with no cameras. A nurse of the same gender as the patient conducts the skin assessment. A separate staff member inspects the patient's clothing for contraband and returns it to the patient after the skin assessment has been completed for the patient to wear. • Written documentation and posttest will be completed prior to May 23, 2018 for nursing staff. • Incident of this nature will be immediately reported to the CNO. • Incidents of patient right violations will be reported immediately to the CNO. The CNO will give instructions of initiation of investigation. • All incidents of patient rights violations will be that have been confirmed must be reported to the state 24 hours and	March 16, 2018
A 143	PATIENT RIGHTS: PERSONAL PRIVACY CFR(s): 482.13(c)(1) The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to protect a patient's right to personal privacy. Failure to provide for privacy puts patients at risk for loss of personal dignity and psychological harm. Findings included: 1. Document review of the hospital's policy and procedure titled, "Unclothed Body Search/Property Search," no policy number, revised 05/17, showed that at all times, staff must protect the privacy and dignity of the patient during the search procedure. Staff members of the same gender as the patient must perform the search in complete privacy. Document review of the hospital's policy and procedure titled, "Patient Rights," no policy number, effective 05/17, showed that the hospital shall recognize and respect the personal dignity of the patient at all times. Rights, which may not be limited, include being treated with respect and dignity.	A 143		

investigation completed within 60 days.
- All incidents of patient rights violations will be corrected immediately.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- Nursing supervisors will report to the Chief Nursing officer (CNO) of all admits and locations that skin checks were performed.
- Nurses will provide an incident report of any skin checks not done privately.
- Security footage from the S/R rooms will be reviewed from the previous day or weekend on Monday's to ensure that no skin checks have been conducted in these rooms. Auditing will be number of patients admitted in the month that had skin checks not done in the S/R room over the number of admits. This will be reviewed until 100% compliance is reached for one continuous month with findings reported to the PI committee. If compliance goes below the threshold of 95% for 1 month a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month than spot checks will be conducted on a monthly. Identified issues will be reported to the CNO.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Any process violating the patient's privacy will be reported to CNO and to the PI Committee.
- Any rights violations will senior leadership immediately.
- Any rights violations will be reported in daily management meeting.

			Individual Responsible: John Beall, Chief Nursing Officer **Date Completed:** March 16, 2018	

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A 143	Continued From page 34 2. On 03/05/18 at 2:57 PM, Surveyor #5 and a registered nurse (Staff #502) inspected the seclusion and restraint room on the second floor. The nurse stated that the room is also used when admitting new patients to the hospital. Staff #502 also stated it is the hospital's procedure to have them stand in view of the camera when doing the skin check. 3. On 03/13/18 at 10:30 AM, Surveyor #3 and the hospital educator (Staff #301) inspected the "quiet room" on the first floor of the hospital. Staff #301 stated that the hospital has two quiet rooms, one for each floor. Staff members take patients to the quiet room when they require seclusion or restraint monitoring. The quiet room has a video camera located in the corner of the room and is continuously monitored and electronically recorded. Staff #301 stated that new hospital patients are also taken here to have a skin check assessment performed as part of their admission. Surveyor #3 asked Staff #301 how the hospital maintains patient privacy during continuous video recording. She stated that the patient is positioned near the front of the bed so that only their head is visible. The patient receives instruction to expose only one segment (e.g. an arm, a leg) of their body at a time. 4. On 03/14/18 at 2:50 PM, Surveyor #3 and Staff #301 reviewed a recording dated 03/14/18 at 7:50 PM of a patient being admitted to the hospital. The video recording showed a staff member as they escorted a young adolescent female patient in a hospital gown into the quiet room for the skin check assessment. During the video review, the surveyor observed the following:	A 143		

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A 143	Continued From page 35 a. The patient points to the open door and requests for it to be closed. b. The hospital staff member (Staff #303) closed the door. c. The patient pointed to the video camera located in the corner of the quiet room. The patient's facial expression is consistent with a person experiencing anxiety and nervousness. d. During the skin check assessment process, the patient's breasts, buttocks, and groin area were clearly visible and not blocked from the view of the video camera at any time. 5. Immediately following the review of the video recording, Surveyor #3 interviewed the hospital educator (Staff #301) about the observed skin check process. Staff #301 stated that the skin check "did not happen how we are supposed to do this." When the surveyor asked why the skin checks do not occur on the nursing unit, she stated that there is no exam room on the unit and the hospital prefers not to perform skin checks in the patient's room.	A 143		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: ITEM #1- Safe from Self-Harm: Suicide Precautions	A 144	**Plan of Correction for Each specific deficiency Cited:** (A 144) The facility did not ensure that suicidal patients received care in a safe setting. This posed a serious risk of harm due to: • Failure to provide adequate monitoring of patients admitted for suicidal ideation or assessed at risk for suicide in order to prevent future attempts. • Failure to notify the patient's provider following a suicide attempt. • Failure to increase monitoring following a suicide attempt. • Failure to develop and implement a policy that provides clear direction for staff for monitoring of patients who have expressed suicide ideation or made suicide attempts.	March 8, 2018

Procedure/process for implementing the plan of correction:

The Chief Nursing Officer immediately corrected the suicide risk of harm finding by:

- The "Precaution: Suicide" policy was revised to delineate line of sight, Q 5 minute, and 1:1 observation categories. The revised policy provides instruction to staff to immediately notify the physician/provider for HIGH or SEVERE risk of suicide (at time of assessment) and any suicide gestures or suicide attempts. Further, the policy instructs staff to notify the CEO for any suicide attempts. The policy provides that the minimum level of observation for a patient on suicide precautions is "every five minutes." Based on assessment criteria and a conversation with the provider, this level of observation may be increased to "line of sight" or "1:1" level. The observation is based on the specific information related to the identified concern, in addition to general suicidal precautions. This information is to be handed off to all staff conducting monitoring of this patient.The policy also states that additional interventions for the patient will be placed into the treatment plan.
- The "Precaution: Suicide" policy was revised to instruct the nurse to document in the medical record the event, the actions taken by the nursing staff, the response of the patient, the notification of the practitioner and orders received and the institution of actions taken in response to the orders taken. Documentation also must include all others notified of the event, including CEO, CNO, Nursing Supervisor, family members, and all others notified.
- The "Precaution: Suicide" policy was revised to include that an incident report will be completed by the staff member documenting any suspected suicide attempt.
- The Suicide Risk Assessment was revised to include notification to the CNO for patients at HIGH or SEVERE risk of suicide upon admission by the intake department.
- The admission orders were changed to reflect three possible choices for patients at risk of suicide: Q 5 minutes, Line of Sight, or 1:1.
- A separate order sheet template was created for use later during a patient's stay should he/she become suicidal.

The Medical Director will train the practitioners to verbally inform nurse of new orders and flag the new orders. This occurred by March 8,2018.

The CNO will retrain the nurses to:

- Immediately notify the physician/provider of any HIGH or SEVERE risk of suicide and of any suicide gesture or attempt reported and documented upon admission.
- Notify the CEO of any suicide attempts.
- Immediately increase the level of observation for any patient who attempts suicide while in the hospital & then notify the physician/provider.
- Update the patient's treatment plan to reflect the need for the increased level of observation, and
- Notify their nurse manager and/or the staffing coordinator of the new order so that an assessment may be made to allocate proper staffing resources.

This education occurred by March 8,2018

All nursing staff were re-trained on Suicide policies and procedures, and danger to self and/or others treatment planning, by March 8, 2018. In order to demonstrate

competency each nursing staff was tested, and documentation placed in the employees HR file.

- White boards will be audited by Nurse Managers to ensure accuracy of suicide precautions are listed and accurate. If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month than spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported to the CNO
- Audits by the daily audit team are conducted for the high risk notification page, intake assessment form with suicide assessment, and nursing assessment are in alignment and are reviewed 5 days a week on 15% of the medical records on a continual basis to ensure that appropriate precautions and observations have been ordered. If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month then spot checks of 2 medical records will be reviewed for the items monthly. Identified issues after the 100% monthly compliance will be reported to the CNO for follow up.

- Suicide precautions will be communicated during shift report.

The nursing report sheet will be used to maintain an accurate list of precautions for each client.

- Nurses are ensure the process' was conducted appropriately respecting the patient's dignity and right to privacy, but also protecting the patient's safety.
- Re-education of staff on additional precautions including sexually acting out, assault, and elopement.
- Documentation of alleged or observed incidents in the medical record.
- Re-education of all clinical and nursing staff that treatment plans are updated per observations and incidents requiring an update per CMS and state requirements.
- Auditing to ensure providers assigned correct levels of observation and appropriate orders. 15% of the medical records for each unit will be audited 5 days a week until 100% compliance is achieved for one continuous month. If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month than spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported in the daily chart audit meeting and data available and reported to the PI Committee.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

Nurse Managers will audit the white boards daily and ensure that all information including special precautions is accurate.

			This will be audited with a 100% compliance rating continuously for three months. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • Nurse Managers will audit the white boards daily and ensure that all information including special precautions is accurate. This will be audited with a 100% compliance rating continuously for three months. • The Chief Nursing officer will receive a daily written report of all orders for Suicide Precautions which will be tracked in a log with date order written and date of order discontinued. This will be reviewed daily by the Nurse Manager and attending provider on unit, which will ensure all active Suicide Precautions are being carried out. The Chief Nursing Officer will report out at monthly Performance Improvement meeting for compliance. **Individual Responsible:** John Beall, RN,CNO **Date Completed:** 03/08/2018	

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A 144	Continued From page 36 Based on interview, record review, observation, and document review, the hospital failed to develop and implement a system to monitor patients that reflected the patient's risk for suicide. Failure to adequately monitor suicidal patients placed them at risk of serious injury or death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Precautions: Suicide," effective date 05/17, showed "suicide" is a category the hospital used for newly admitted patients who prior to admission, had attempted suicide or had recent suicidal ideation. The policy also stated that patients placed on suicide precautions will be checked every 15 minutes. The policy also stated that the nurse must obtain an order for "Suicide Precautions I or II," however the policy failed to define the meaning of "Suicide Precautions" and failed to specify differences between "I" and "II." The policy showed conflicting procedures for monitoring as it also directed the nurse to do the following: Review responsibilities and assign one to one supervision; Ensure the observation sheet is initiated for a patient placed on suicide precautions: Take action to adjust staffing as needed, ensuring 1:1 staff have no other duties or responsibilities : Ensure that all aspects of the suicide precautions are completed; Document review of the hospital's policy and procedure titled, "Observation Levels," effective	A 144		

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date 05/17, showed that observation levels are defined as levels of staff awareness and attention to patient safety/security needs. The policy stated that there are specific protocols and required documentation for each observation level. Reasons for the levels of awareness included suicide risk, homicide risk, falls risk, potential for aggressive behavior, or sexually "acting out" behavior. The policy defines the levels of observation as 1:1, constant observation (Line of Sight) and Close Observation (every 15 minutes).

The policy does not address or define interventions for patients who have been placed on suicide precautions or self-harm precautions to ensure patient safety and/or safe environment.

2. On 03/06/18, Surveyor #5 reviewed the discharge medical record of Patient #505 who was admitted on 02/10/18, following a suicide attempt made 24 hours prior to admission to the hospital. On 02/22/18, a provider wrote an order to discharge the patient following administration of morning medications. The medical record review showed the following:

On 02/10/18 at 3:00 AM, the Intake Call Sheet showed that the precipitating event requiring the hospitalization was a Suicide Attempt with plan to hang self, attempt to strangle self with bed sheets the prior night, and Command Auditory Hallucinations to hang himself or run into traffic .

The Intake Assessment completed on admission showed that the patient was at high risk for suicide, had made prior attempts of suicide by hanging, 2 months ago and one year ago, and the patient currently reported he had ongoing suicidal ideation with plans to hang himself.

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A 144	Continued From page 38 On 02/10/18 at 4:30 PM, an admitting provider wrote an order to place the patient on suicide precautions and self-harm precautions with close observation and 15-minute checks. The Patient Observation Record reflected the provider's order. On 02/12/18 at 1:06 PM, a provider wrote an order to discontinue all unit restrictions. The patient observation record showed that the patient was removed from suicide precautions but remained on self-harm precautions and was checked every 15 minutes. On 02/16/2018 at 3:15 PM, the patient attempted suicide by hanging himself with his bed sheets. The report showed that the patient was initially unresponsive but responded to sternal rub and the patient was transported to an Emergency Department at a medical hospital via ambulance. On 02/17/18 at 1:06 PM, a provider order stated to continue suicide precautions. On 02/18/18 at 5:00 PM, a provider order stated to discontinue suicide precautions, start close observation and every 15-minute checks and staff supervision was required for the patient to have blankets or beds sheets during sleep. On 02/19/18 at 11:30 AM, a nursing note showed that the patient made a second suicide attempt. The hospital transferred the patient to the 2- West unit for a higher level of care The Patient Observation Records dated 02/19/18, showed that the patient was placed on suicide precautions, self-harm precautions and every	A 144		

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A 144	Continued From page 39 15-minute checks. The Patient Observation Records dated 02/20/18, 02/21/18, and 02/22/18 showed that the patient was not on suicide precautions but was on self-harm precautions and every 15-minute checks. 3. On 03/06/18, Survey #5 reviewed the discharge medical record of Patient #506 who was admitted on 01/07/18 for the treatment of alcohol dependence and depression. The medical record review showed the following: The Intake Assessment completed on admission showed that the patient had attempted to kill himself the previous night by overdosing on prescription medication. The patient was reporting Command Auditory Hallucinations (CAH) to kill himself on prescription meds or by hanging himself and current suicidal ideation with plan and access. The patient was assessed at "High Risk" for suicide with a total score of 54. On 01/07/18 at 11:02 AM, the provider wrote an order to place the patient on suicide precautions. The provider failed to indicate the "Level of Observation" on the form. The Patient Observation Record from 01/07/18 and 01/08/18 showed that the patient was on suicide precautions, self-harm precautions and checked every 15 minutes. On 01/09/18 at 5:40 PM, the patient attempted suicide by hanging himself with a bed sheet tied around his neck that had a knot tied in the other end and the knotted end placed over the top of the bathroom door. Following the incident, a	A 144		

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A 144	Continued From page 40 provider ordered a 1:1 sitter "stat" (immediately) and a medical consult for suicide attempt via hanging. The Patient Observation Record from 01/09/18 and 01/10/18, showed that the patient was on suicide precautions, self-harm precautions, 1:1, and checked every 15 minutes. On 01/10/18 at 2:00 PM, a provider wrote an order to discontinue the 1:1 monitoring and start Line of Sight monitoring. On 01/11/18 at 10:45 AM, a provider wrote an order to continue line of sight, every 5-minute night checks but the form used for documentation only identified 15-minute checks. 4. On 03/06/18, Surveyor #5 reviewed the discharge medical record of Patient #507 who was admitted on 02/09/18 for major depressive disorder and post-traumatic stress disorder. The medical record review showed the following: The Intake Assessment showed that the patient had physically assaulted his father, had increased aggressive behavior toward family, and per the family, had been sleeping with a knife under his pillow. The patient was assessed at moderate risk of suicide. . On 02/09/18 at 12:00 PM, the admitting provider ordered the patient placed on close observation with 15-minute checks. On 02/15/18 at 9:30 PM, hospital staff found the patient in his room with a flat sheet tied into a noose. A nursing progress note shows that staff texted a picture of the noose to the Chief Nursing	A 144		

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Officer (CNO), (Staff #501) and that the nurse manager was contacted to determine if 1:1 staffing was available. The note stated, "It was determined that all clothing and bedding, except for fitted sheet and blanket would be removed and the patient would be observed aggressively. Consequently, patient was rounded on (every) 15 minutes."

Surveyor #5 found no evidence in the medical record that hospital staff notified the physician about the event nor did the record show any evidence of orders to increase monitoring.

The Patient Observation Records for 02/16/18 through the patient's discharge on 02/20/18 showed that the patient was on suicide precautions with every 15-minute monitoring.

5. On 03/07/18 at 11:08 AM, Surveyor #5 and a Registered Nurse (Staff #508) reviewed the medical record for Patient #508 who was admitted on 02/15/18 for the treatment of post-traumatic stress disorder, depression, and suicide attempt.

The Intake Assessment completed on admission showed that the patient had self-harm behavior, a history of suicide attempts, and had taken a knife with her to her provider appointment and made threats to stab herself. The patient was assessed at high risk for suicide.

On 02/15/18 at 9:45 AM, a provider wrote an order to place the patient on suicide precautions with close observation and every 15-minute checks. On the same date, The Patient Observation record reflected the 15-minute checks, but the record did not include suicide

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A 144	Continued From page 42 precautions until 02/16/18. On 02/17/18 at 11:00 AM, a Psychiatric progress note stated, "(Patient #508) attempted to hang herself this a.m., and verbalizes her continued desire to die as she no longer wants to deal with her mental illness." On 02/17/18 at 11:05 AM, a provider wrote an order to begin room lockout and self-harm precautions. On 02/20/18 at 9:00 PM, a Registered Nurse progress note showed that the patient alerted staff that she was suicidal and wanted to harm herself. Staff initiated 1:1 monitoring to keep the patient safe. On 02/20/18 at 11:30 PM, a provider wrote an order to increase security to every 5-minute checks for suicidal ideation. The Patient Observation Record reflected the increased frequency of patient checks. On 02/22/18 at 12:00 PM, a provider wrote an order to discontinue line of sight. 6. On 03/07/18, Surveyor #5 reviewed the medical record of Patient #509, who was admitted on 02/16/18 for the treatment of suicidal ideation and bipolar disorder. The Intake Assessment completed on admission showed that the patient presented with suicidal ideation with a plan to run into a train and a long history of suicidal ideation with multiple attempts. The patient was assessed at "High Risk" for suicide.	A 144		

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A 144	Continued From page 43 On 02/17/18 at 12:10 AM, the admitting provider wrote an order to place the patient on close observation with 15-minute checks. The patient was not placed on suicide precautions, however the Patient Observation records from 02/16-02/19/18 indicated the patient was on "self-harm precautions". On 02/18/18 at 6:00 PM, a provider wrote an order to begin self-harm precautions. On 02/18/18, an untimed Registered Nurse's note showed that the patient was banging her head into the wall and had suicidal ideation with a plan to commit suicide by "banging her head as hard as she can into the wall." - Surveyor #5 could find no evidence in the record that staff took precautions to prevent the patient from banging her head. 7. On 03/08/18, Surveyor #5 reviewed the medical record for Patient #512, who was admitted on 03/03/18 for the treatment of unspecified depression after she attempted suicide by overdosing on clonazepam (an anti-anxiety drug), and alcohol which resulted in a motor vehicle accident. The medical record review showed the following: The Intake Assessment completed on admission showed that the patient had current suicidal ideation with a plan, intent, and access, and had drove her car into traffic. The patient was assessed at "High Risk" for suicide. On 03/03/18 at 9:30 AM, the provider wrote an order for unit restrictions. The provider did not order suicide precautions with every 15-minute	A 144		

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A 144	Continued From page 44 checks until 3 days later on 03/06/18 at 8:00 PM. 8. On 03/05/18 at 2:20 PM, Surveyor #5 interviewed a Mental Health Technician (Staff #504) about what it meant to be on suicide or assault precautions. Staff #504 stated that it meant that staff needed to be aware of the patient's actions. 9. On 03/06/18 at 4:00 PM, Surveyor #5 interviewed the Chief Nursing Officer (CNO) (Staff #501) about the suicide attempt findings and the hospital's policy and procedures for patients admitted at risk for suicide. Staff #501 stated that actively suicidal patients should be placed on 1:1 monitoring. 10. On 03/07/18 at 11:44 AM, Surveyor #5 interviewed a Registered Nurse (Staff #507) about suicide precautions for patients who are admitted at risk for suicide. Staff #507 stated that patients are "only put on 1:1 monitoring if they do something at this facility." 11. On 03/07/18 at 12:05 PM, Surveyor #5 interviewed a Registered Nurse (Staff #508) about the hospital's policy and procedure for patient assessed at risk for suicide. Staff #508 stated that when patients are on suicide precautions, they get their room checked every day and they get no extra linen. She stated that suicidal patients are supposed to have safety blankets, but they are not available. She stated that the department was very busy and had many suicide attempts. She stated that recently 3 patients attempted suicide on her shift on the same day, there was not enough staff, and so they locked all the patients out of their rooms for safety. She stated that she felt "it was only a	A 144		

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A 144	Continued From page 45 matter of time until someone dies, because when patients need 1:1 staff for safety there is no one available help". 12. On 03/08/18 at 11:00 AM, Surveyor #5 interviewed a Registered Nurse (Staff #509) and a Mental Health Technician (Staff #510) about the hospital's policies and procedures for monitoring patients at risk for suicide or those on suicide precautions. Staff #509 and Staff #510 stated that there was no difference in the monitoring. Patients on suicide risk precautions received the same 15-minutes checks as all other patients in the unit. ITEM #2- Safe from Self Harm/Harm to Others: Line of Sight Precautions Based on interview, record review, observation, and review of policy and procedure, the hospital failed to develop and implement a system to ensure the safety of 4 of 4 patients (Patient #501, #502, #503, and #504) who had been placed on line of sight precautions for being a danger to self or others. Failure to protect patients from self-harm and harm by other patients and failure to properly communicate patients' risk of self-harm, harm to other patients or harm to unit staff members, posed a serious threat to the health and safety of all patients and staff, which could result in serious injury and death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Observation Levels," effective	A 144		

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A 144	Continued From page 46 date 05/17, showed that patients placed in Line of Sight (LOS) precautions should be in visual range of the assigned staff at all times. Document review of the hospital's policy and procedure titled, "Precaution: Suicide," effective date 05/17, showed that LOS precautions is a level of precaution used for patients who represent an active suicide risk. 2. On 03/05/18 at 1:40 PM, Surveyor #5, a Registered Nurse (Staff #502) and the Director of Education and Infection Prevention (Staff #503) inspected the hospital's 2-North unit. At the time of the inspection, Surveyor #5 asked Staff #502 and Staff #503 if there were any patients on the unit who were in restraint/seclusion, or on suicide, 1:1, or LOS precautions. Staff #502 and #503 stated that there were no patients on the unit in restraint/seclusion, or on suicide, 1:1, or LOS precautions. 3. On 03/05/18 at 2:10 PM, Surveyor #5 reviewed the medical record of Patient #501 who was admitted on 02/24/18 for stabilization and treatment of continuing suicidal ideation (SI) with intention to harm herself. The patient was previously diagnosed with bipolar disorder, self-injurious behavior by cutting herself, auditory hallucinations, a history of three suicide attempts, and an attempt to choke herself on a previous admission to Smokey Point Behavioral Hospital. The medical record review showed: On 02/25/18 at 1:45 AM, the patient was assessed at high risk for suicide and placed on suicide precautions. On 03/01/18, the provider placed the patient on	A 144		

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A 144	Continued From page 47 1:1 monitoring for disruptive behavior. On 03/02/18, a physician discontinued the 1:1 monitoring and placed the patient on LOS monitoring with directions to "keep out of room during daytime, must stay by nursing station. Q5 minute (every five minutes) checks while in bed." On 03/03/18, the hospital moved the patient to the 2-North unit after she assaulted multiple staff members. On 03/04/18 and 03/05/18, the daily observation sheets showed the patient was on suicide, self-harm, assault/homicide precautions but was only on every 15 minute checks, not LOS monitoring or Q5 minute checks while in bed. On 03/05/18 at 4:30 PM, Surveyor #5 reviewed the hospital's list for LOS precautions provided by the Chief Nursing Officer (Staff #501). The list did not include Patient #501. On 03/05/18 at 2:30 PM, Surveyor #5 interviewed the Charge Nurse (Staff #502) about monitoring for Patient #501. Staff #502 confirmed the physician order for LOS precautions and stated that the patient was not being monitored on LOS. 4. On 03/05/18 at 2:35 PM, Surveyor #5 and Staff #502 reviewed the medical record of Patient #502, who was located on the 2-North unit and who was admitted on 10/30/17 for the treatment of Schizoaffective disorder, Bipolar type F25, and anorexia/bulimia. The medical record review showed the following: Prior to transfer to this hospital, the patient assaulted a nurse and a security officer in the emergency department and the patient continued	A 144		

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A 144	Continued From page 48 to exhibit disorganized and disruptive behavior. On 02/08/18 at 8:00 PM, a physician wrote an order for the patient to be on LOS precautions while in the milieu and have every 15-minute checks while in the bedroom. On 03/05/18 at 2:44 PM, Surveyor #5 interviewed the Charge Nurse (Staff #502) about the observation status for Patient #502. The Charge Nurse confirmed the physician order for LOS precautions and stated that the hospital staff was not monitoring the patient consistent with the provider's order. On 03/05/18 at 4:30 PM, Surveyor #5 reviewed the hospital's list for LOS precautions provided by the Chief Nursing Officer (Staff #501). The list did not include Patient #502. 5. On 03/12/18, Surveyor #5 reviewed the medical records for Patient #503 and #504, who were located on the 2-West unit. The review of their medical records showed both patients received provider orders for line of sight monitoring. On 03/13/18 at 8:50 AM, Surveyor #5 and the Senior Vice President of Clinical Services (Staff #505) observed the 2-West unit as staff performed LOS precautions. The observation showed there was no staff performing LOS monitoring. Surveyor #5 and Staff #505 interviewed a Mental Health Technician (MHT) (Staff #506), who at the time was reviewing paperwork behind the nurse's station, about the patients on the units with LOS monitoring for harm to self or others. The MHT	A 144		

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A 144	Continued From page 49 stated that there was only one person on LOS monitoring and pointed toward Patient #504, but failed to identify Patient #503. Surveyor #5, Staff #505, and Staff #506 reviewed the medical record for Patient #503 for any change in the physician LOS orders. The medical record review showed no change in the physician order. 6. On 03/05/18 at 2:20 PM, Surveyor #5 interviewed a Mental Health Technician (Staff #504) about staff monitoring of patients on safety precautions. Staff #504 stated that there is no designated person to do LOS monitoring. She stated that there used to be extra staff when patients were placed on LOS monitoring to watch them but that no longer happens. Surveyor #5 asked Staff #504 what happens when there are multiple patients on LOS. Staff #504 stated that sometimes they do "lock outs" (locking all the patient room doors so patents cannot enter their room unless let in by a staff member) to keep patients in the milieu so they can be observed. Item #3 - Free from Abuse Based on observation, interview, and review of hospital documents, the hospital failed to develop and implement effective policies, procedures, and interventions to protect patients from abuse in two occurrences involving four patients (Patient #522, #523, #524, #915). Failure to ensure effective processes are in place to protect patients from abuse risks serious harm to patients due to physical and psychological injury.	A 144		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 144	Continued From page 50 Findings included: 1. Document review of the hospital's policy and procedure titled, "Precautions: Assault/Homicidal Risk," effective date: 05/17, showed that any patient who, because of previous history, or any other reason in the opinion of the physician, is regarded as potentially assaultive and/or homicidal may be placed on assault precautions. The policy stated that: -The patient is to be placed on unit restriction and monitored every 15 minutes -Staff will notify other unit staff and the Activity therapist that the patient is on Assault/Homicidal Risk Precautions -A sticker labeled "Assault/Homicidal Precautions" is placed on the front of the chart -A safety plan is placed in the master treatment plan -The unit staff will complete and route the "Restriction from Rights" form However, the policy failed to identify measures/interventions to prevent patient-to-patient assaults and failed to address measures/interventions for assaults between roommates. 2. On 03/06/18 at 9:00 AM, Surveyor #11 interviewed a provider (Staff #514) regarding an occurrence of sexual relations between two patients (Patients #523 and #524). Staff #514 stated that Patient #523 had sex with a developmentally disabled adult with the cognitive abilities of a ten-year-old child (Patient #524). She stated the patient was a predatory sociopath who took phone numbers from vulnerable patients.	A 144		

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A 144	Continued From page 51 Staff #514 stated that the facility had no system where they could stage or classify patients before placement. 3. On 03/07/18 Surveyor #5 reviewed the medical record of Patient #524, a developmentally delayed female who was admitted on 02/04/18 for the treatment of Bipolar I with psychotic features with a history of persistent delusions of having a "spiritual baby", sexually inappropriate behaviors, and jumping out of a moving car. The review of the medical record showed the following: On 02/12/18 at 2:20 PM, a Psychiatric progress note shows that the patient "..remains gravely disabled and high risk for victimization/running away in community and requires further treatment." On 02/13/18 at 9:40 AM, a Psychiatric progress note shows that hospital staff found the patient overnight having sexual intercourse with a patient. The report stated that Patient #524 entered Patient #523's room and propositioned intercourse. The note stated that the patient will remain on sexually inappropriate behavior precautions. On 02/13/18 at 11:30 AM, a note by a Mental Health Professional stated, "Spoke to (Patient #524) and asked her to talk about what had happened between her and a male patient last night. She stated, 'we had sex in my bathroom and in his bathroom.' The writer asked if the sex was consensual and (the patient) replied "yes.' She said, 'he was sent by God to have babies with me. I can tell by his face. He has the face of the person sent by God."	A 144		

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A 144	Continued From page 52	A 144		

4. On 03/13/18, Surveyor #5 reviewed the medical record of Patient #523 who staff members found having sexual intercourse with Patient #524. The medical record review showed that Patient #523 was admitted on 02/04/18 for the treatment of auditory voices telling him to kill himself, attempted suicide, and a history of schizoaffective disorder. The review of the medical record showed the following:

On 02/04/18 at 6:25 AM, the admitting provider wrote orders for unit restrictions for 24 hours and close observation with 15-minute checks. The provider did not order assault/homicidal precautions or suicide precautions.

On 02/12/18 at 11:37 PM, a nurse wrote a nursing order for sexual aggression precautions that required the patient to maintain 5-feet of distance from all female patients.

Surveyor #5 found no evidence that the hospital initiated interventions to protect other patients from abuse prior to the encounter.

5. On 03/14/18 at 9:45 AM, Surveyor #5 and a Registered Nurse (Staff #513) reviewed the medical record of Patient #522 who was admitted on 02/11/18 for the treatment of Schizophrenia, audio and visual hallucinations and paranoid delusions. The review of the medical record showed the following:

On 02/11/18 at 5:10 AM, a provider wrote an order to place the patient on assault/homicidal precautions with close observation and 15-minute checks.

On 02/17/18 at 3:30 AM, a Registered Nurse

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A 144	Continued From page 53	A 144		

progress note showed that the patient was agitated because she did not like her roommate (Patient #915). The patient assaulted her roommate at 2:00 AM and again at 2:30 AM by pushing her. Patient #915 sustained a shoulder injury.Patient #915 was sleeping in the seclusion room to avoid sleeping in the room with Patient #522. Surveyor #5 found no evidence that staff moved Patient #522 to a different room after she assaulted her roommate.

On 02/18/18 at 11:00 PM, a provider wrote an order for Patient #522 to be on Assault Precautions due to aggressive assault on staff .

On 02/23/18 at 7:30 PM, a Registered Nurse progress note showed that the patient was threatening, verbalizing, and yelling at staff and patients and struck at and kicked another patient.

On 02/24/18 at 5:06 AM, Registered Nurses' progress notes showed that Patient #522 was assaultive toward a patient and punched that patient in the jaw. Patient #522 was also assaultive toward staff and required physical restraint.

Surveyor #5 found no evidence that staff members moved the patient to a different room after this assault.

6. At the time of the review, Surveyor #5 asked the Registered Nurse (Staff #513) what interventions staff members initiate to keep patients safe from other patients who are on Assault Precautions. Staff #513 stated, "It is just an awareness, it means staff are aware."

Surveyor #5 also asked Staff #513 if there was

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A 144	Continued From page 54 any increased monitoring of patients on Assault Precautions. Staff #513 stated that the "patients are on every 15 minute checks, which is the same for all patients."	A 144		
A 166	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(4)(i) The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on policy review and review of patient records, the hospital failed to modify the patients' plan of care after placing patients in restraints. Failure to modify care plans when patients are in restraints, placed patients at risk of harm by not meeting physical and emotional needs. Findings included: 1. Document review of the hospital policy titled, "Use of Restraints," effective 05/17, showed that as part of documentation requirements, if restraint or seclusion are used it should be added to the "Master Treatment Plan." 2. Surveyor #9 reviewed the records of 5 patients who were placed in restraints (Patients#901, #902, #903, #904, #905). Five of five records did not have an updated treatment plan to reflect the patient being placed in restraints as per hospital policy.	A 166	**Plan of Correction for Each specific deficiency Cited:** (A 166) The Hospital failed to adequately respond and update a patient's Master Treatment Plan after a Seclusion and Restraint incident. **Procedure/process for implementing the plan of correction:** • Nursing will alert the Clinical Services from the prior day via Email • Re-training will be provided to all Clinical Services Staff involved with treatment planning by 5/23/2018. During the training, emphasis was made ensuring a patient's Master Treatment Plan is reviewed and updated after any Seclusion and Restraint incident. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The Director of Clinical Services will follow-up with any Clinical Services staff person after a reported Seclusion and Restraint incident with a patient to ensure the Master Treatment Plan	May 23, 2018

is reviewed and updated. The Director of Clinical Services will also conduct chart audits weekly to ensure such updating is completed.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

15% of medical records will be audited for master Treatment Plans will have the identified problem of a patient according to DTO or DTS including but not limited to change in status or seclusion/restraint- 5 times a week by the daily auditing team for accuracy and completeness and reported back to the Director of Clinical Services this will continued until 100% compliance has been accomplished. If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month then spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported to the Director of Clinical Services for follow up.

Data will be reported to the Performance Improvement committee.

Individual Responsible:

Leah Jones, MSW, LICSW, CDP, Director Clinical Services

Date Completed:

5/23/2018

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A 166	Continued From page 55 3. On 03/13/18, Surveyor #5 reviewed the medical record of Patient #527 who was admitted on 10/06/17 for the treatment of psychosis, and suicidal ideation. The record review showed 24 episodes of restraint between 10/10/17 and 11/13/17. Review of the treatment plan showed that the treatment plan was never updated to reflect the patient being placed in restraints per hospital policy. - On 03/13/18 at 9:40 AM, the Chief Nursing Officer (Staff #501) confirmed the finding. 4. On 03/14/18, Surveyor #5 reviewed the medical record for Patient #522 who was admitted on 02/11/18 for the treatment of Schizophrenia, Audio and Visual Hallucinations and Paranoid Delusions. The record review showed seven episodes of restraint or seclusion from 02/18/18 to 02/23/18. Review of the treatment plan showed that the treatment plan was never updated to reflect the patient being placed in restraints per hospital policy. -At the time of the record review, a Registered Nurse (Staff #513) confirmed the finding.	A 166	**Plan of Correction for Each specific deficiency Cited:** (A 167) The Hospital failed by having missing documentation in the medical record. **Procedure/process for implementing the plan of correction:** • Nurses were re-educated on proper documentation and orders of a patient placed in seclusion or restraint on March 22, 2018. • Nurses will notify the CNO of the event by scanning all completed S/R documentation to the CNO for review. • The review will include: o patient's response to the intervention, o medications given, o patient monitoring, o fluids and meals offered, o personal hygiene needs met, o information given to patient regarding behavior required for removal, o documentation of patient and staff and patient debriefing following the use of restraints.	May 23, 2018
A 167	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(4)(ii) [The use of restraint or seclusion must be--] (ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.	A 167		

			Monitoring and Tracking procedures to ensure the plan of correction is effective: • Medical record documentation for S/R from the previous day will be reviewed by the CNO daily on above items stated in the corrective action plan. Nurse management/supervisors will continue to review all S/R documentation on an ongoing basis and report compliance to the PI committee. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • Audit results will be reported to the PI committee. **Individual Responsible:** John Beall **Date Completed:** May 23,2018	

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A 167	Continued From page 56 This STANDARD is not met as evidenced by: . Based on record review and review of the hospital's policies and procedures, the hospital failed to ensure that staff members followed the hospital's restraint policy and procedure for 7 of 7 records reviewed (Patients #522, #527, #901, #902, #903, #904, and #905). . Failure to follow established policies and procedures places patients at risk of physical and psychological harm and possible violation of patient rights. . Findings included: 1. Document review of the hospital's policy titled,"Use of Restraints," effective 05/17, showed that documentation requirements included patient's response to the intervention, medications given, patient monitoring, fluids and meals offered, personal hygiene needs met, information given to patient regarding behavior required for removal, documentation of patient and staff and patient debriefing following the use of restraints. 2. Surveyor #9 reviewed the medical records of five patients placed in restraints. Four of the five patients (Patients #901, #902, #903, #904) did not have complete documentation per hospital policy. Reastraint/Seclusion documentation includes the following: Part 1-Criteria for Seclusion/Restraint use and Criteria for release for Seclusion/Restraint, type of restraint used and less restrictive measure	A 167		

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A 167	Continued From page 57 attempted. Part II- One hour face to face evaluation, MD progress note and validation order Part III- Patient debriefing Part IV- Restraint/Seclusion -Continuous 1:1 monitoring. The records were missing parts I, II, III and IV of the Restraint/Seclusion documentation as required by the hospital policy. 3. Surveyor #9 reviewed the medical record of Patient #905. The face-to-face physician progress note and validation of the order was not signed and dated by the provider who evaluated the patient. 4. On 03/13/18, Surveyor #5 reviewed the medical record of Patient #527 who was admitted on 10/06/17 for the treatment of psychosis, and suicidal ideation. The record review showed 24 episodes of restraint from 10/10/17 and 11/13/17. The reviewed showed that 14 of the 24 of the episodes were missing sections I, II, III and IV of the Restraint/Seclusion documentation as required by the hospital policy and 3 of the 24 episodes were missing parts III and IV of the Restraint/Seclusion documentation as required by the hospital policy. -On 03/13/18 at 9:40 AM, the Chief Nursing Officer (Staff #501) verified the findings and stated that sections I-IV should be completed for each episode of restraint. 5. On 03/14/18, Surveyor #5 reviewed the	A 167		

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A 167	Continued From page 58 medical record for Patient #522 who was admitted on 02/11/18 for the treatment of Schizophrenia, Audio and Visual Hallucinations and Paranoid Delusions. The record review showed seven episodes of restraint or seclusion from 02/18/18 to 02/23/18. The review showed that one of seven episodes was missing sections I, II, III and IV of the Restraint/Seclusion documentation as required by the hospital policy and one of seven was missing sections II, III and IV of the Restraint/Seclusion documentation as required by the hospital policy. -On 03/13/18 at 9:35 AM, a Registered Nurse (Staff #513) verified the missing documentation and stated that all sections should be completed.	A 167	**Plan of Correction for Each specific deficiency Cited:** (A 168) The Hospital failed by having missing documentation in the medical record. **Procedure/process for implementing the plan of correction:** • Nurses were re-educated on proper documentation and orders of a patient placed in seclusion or restraint on March 22, 2018. • Nurses will notify the CNO of the event by scanning all S/R documentation to the CNO for review. • Nurses were re-educated to communicate that the order is written within 1 hour and signature obtained in 24 hours. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Medical record documentation for S/R from the previous day will be reviewed by the CNO daily on above items stated in the corrective action plan. Nurse management/supervisors/CNO will continue to review all S/R	May 23, 2018
A 168	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(5) The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on review of medical records and interview, the hospital failed to ensure that a licensed provider wrote an order for restraints for 2 of 6 records reviewed (Patient #522 and #902). Failure of a provider to write an order for the use of restraints could lead to poor documentation	A 168		

			documentation on an ongoing basis and report compliance to the PI committee. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • Audit results will be reported to the PI committee. **Individual Responsible:** John Beall **Date Completed:** May 23,2018	

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A 168	Continued From page 59 and monitoring for patient's condition. Findings included: 1. Document review of the hospital's policy titled, "Use of Restraints," effective 05/17, showed that restraints must be ordered by a physician. 2. Surveyor #9 reviewed the medical records of five patients placed in restraints. Patient #902 did not have an order for a restraint placed on 12/27/17. 3. On 03/14/18, Surveyor #5 reviewed the medical record for Patient #522 who was admitted on 02/11/18 for the treatment of Schizophrenia, Audio and Visual Hallucinations and Paranoid Delusions. The record review showed seven episodes of restraint or seclusion from 02/18/18 to 02/23/18. The reviewed showed that two of seven episodes were missing a physician order for the restraint. -On 03/13/18 at 9:35 AM, a Registered Nurse (Staff #513) verified the finding.	A 168		
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the	A 263	**Plan of Correction for Each specific deficiency Cited:** (A 263) The Hospital failed to: • Failure to collect, aggregate and analyze data to improve patient outcomes • Failure to analyze data to determine factors that contribute to patient injury • Failure to develop projects and action plans based on results of data collection and aimed at improving patient outcomes • Failure of the governing body to ensure a hospital-wide quality program **Procedure/process for implementing the plan of correction:** The Performance improvement committee convened a meeting on 3/27/2018 with the directors of departments in order to initiate an updated dashboard that will review all required items to be communicated further to the governing body. The new dashboard will be approved at the next meeting and sent to the governing board for approval. This includes: • Aggregated data on patient outcomes (outcomes data will begin to be collected by 4/30/2018) • Quality Improvement projects by each department to be presented and approved first by Performance Improvement Committee then by the Governing board.	May 23, 2018

			• Data, factors and recommendations by the PI Committee to the governing board on contributable patient injuries. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • A new dashboard is being created for governing body approval and will be sent for approval. • The PI Director will report any failure to submit data to the CEO. • Directors have approved to move forward on the new dashboard for governing body approval. Final draft will be approved at next Performance Improvement Committee. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • The new approved dashboard and reports from committees will be communicated per policy to the governing board on a regular basis. **Individual Responsible:** Ryan Robertson, Director of PI and Risk **Date Completed:** May 23, 2018	

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A 263	Continued From page 60 hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on interview, document review and review of quality documents, the hospital failed to develop a hospital-wide quality assessment and performance improvement (QAPI) plan to monitor, evaluate, and improve the quality of patient care services through systematic data collection and analysis. Failure to systematically collect and analyze hospital-wide performance data limited the hospital's ability to identify problems and formulate action plans. This reduced the likelihood of sustained improvements in clinical care and patient outcomes. Findings included: Failure to collect, aggregate and analyze data to improve patient outcomes Failure to analyze data to determine factors that contribute to patient injury Failure to develop projects and action plans based on results of data collection and aimed at improving patient outcomes	A 263		

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A 263	Continued From page 61 Failure of the governing body to ensure a hospital-wide quality program Based on the scope and severity of deficiencies identified under 42, CFR 482.13 Conditions of Participation for Patient Rights, 42 CFR 482.22 Conditions of Participation for Medical Staff, 42 CFR 482.23 Conditions of Participation for Nursing Services and other deficiencies identified under 42 CFR 482.21 Conditions of Participation for Quality Assessment and Performance improvement Program are NOT MET. Cross Reference: A0115, A0273, A0286, A0297, A0308, A0338, A0385	A 263	**Plan of Correction for Each specific deficiency Cited:** (A 273) The Hospital failed to: • Keep the Hospital Performance improvement dashboard updated and communicated to the governing body. **Procedure/process for implementing the plan of correction:** The Performance improvement committee convened a meeting on 3/27/2018 with the directors of departments in order to initiate an updated dashboard that will review all required items to be communicated further to the governing body. The new dashboard will be approved at the next meeting and sent to the governing board for approval. This includes: • A new study on patient outcomes (outcomes data will begin to be collected by 4/30/2018) • Quality Improvement projects by each department and committee to be presented and approved first by Performance Improvement Committee then by the Governing board. • Data, factors and recommendations by the PI Committee to the governing board on contributable patient injuries. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • A new dashboard is being created for	May 23,2018
A 273	DATA COLLECTION & ANALYSIS CFR(s): 482.21(a), (b)(1),(b)(2)(i), (b)(3) (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b) Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to--- (i) Monitor the effectiveness and safety of	A 273		

governing body approval and will be sent for approval.

- Directors will include a departmental report as part of participation with the identified items from the PI committee and survey findings including possible trends for discussion at the PI committee while reviewing data.
- Committees will be asked to provide a report and meeting minutes to the PI committee for review of data in the report and identified areas of concern for discussion in the committee.
- All departments are required to have a director/designee attending the meeting for report out.
- Benchmarks on patient outcomes will be identified by the PI committee and approved. Benchmarks form the outcome studies are set to establish improvement from the initial assessment obtained at admission and comparing with the outcome study at the time of discharge.
- These findings have to be greater than 7% improved for the results to be determined valid.
- If there is not an identified improvement then the first stope is to assess the survey process to determine if the process is being followed correctly, since these are APA approved outcome studies.
- Finally the program will be evaluated since it is empirically based.
- The PI and Risk Director will report any negligent data or reports to the CEO for follow up with the department head and communication on acceptable participation.
- Directors have approved to move forward on the new dashboard for governing body approval. Final draft will be approved at next Performance Improvement Committee.
- The Dashboard document including meeting minutes will be sent to the governing board, quarterly

			Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice: • The new approved dashboard and reports from committees will be communicated per policy to the governing board on a regular basis. • The dashboard will be sent to the governing board on a monthly basis. **Individual Responsible:** Ryan Robertson, Director of PI and Risk **Date Completed:** May 23, 2018	

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	504012	A. BUILDING _____ B. WING _____	C 03/15/2018

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A 273	Continued From page 62 services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: . Based on interview, and review of the hospital's quality program and quality documentation, the hospital failed to collect and analyze quality indicator data as part of the hospital's overall quality program. Failure to collect, aggregate and analyze data to improve patient outcomes puts patients at risk of substandard care. Findings included: 1. Document review of the hospital's Performance Improvement Dashboard for 2017 showed the following: a. The hospital identified 138 hospital-wide indicators. Of these, indicators for utilization management, social services, radiology, cardiology, lab services, outpatient, medical outpatient, dietary, human resources, finance, discharge summaries, seclusion, fall risk, and ligature risk had no entries beyond September 2017. b. There was no data collection related to seclusion for 7 of 7 seclusion indicators. There was also no data collection after September 2017	A 273		

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A 273	Continued From page 63 related to restraint use for 6 of 7 restraint indicators. There was no data collection after September 2017 related to patient falls. 2. On 03/08/18, beginning at 1:30 PM, Surveyor #4 interviewed the hospital's Director for Performance Improvement & Risk (Staff #405) about the hospital's quality program data. The staff member stated that department directors are responsible for data submission to him, and acknowledged that there has been no consistent data collection since September, following his predecessor's departure from the position.	A 273	**Plan of Correction for Each specific deficiency Cited:** (A 286) The Hospital Failed to identify and analyze data to determine factors that contribute to patient injury can result in an unsafe healthcare environment due to facility policies.	May 23,2018
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and	A 286	**Procedure/process for implementing the plan of correction:** • The Sentinel Event and Adverse event policies were updated to the current requirements by CMS, Joint Commission and State regulations. • Any state adverse event or Sentinel event will have a root cause conducted. • Senior leadership will be contacted immediately of any event matching the updated definitions to approve reporting the event and conducting a root cause analysis. • The incident report form will be updated to include whether the event was sentinel or adverse, and as to the reason why. • Staff have been re-educated on proper documentation between self-harming behavior and an actual suicide attempt.	

- Providers and staff have been re-educated on proper and clear documentation for events.
- All staff and providers have been re-educated on filling out an incident report prior to them leaving the facility from their shift.
- All staff and providers have been re-educated on accurate documentation and to document events in the record.
- Medication error reports will be reviewed weekly by the Director of Pharmacy and the Nursing department in order to review for any events and follow up then reported to the PI director.
- Medication Errors will be included on the Performance improvement dashboard for reporting to the governing body.
- Any medication error events of a serious nature will be reported during the daily huddle, and communicated by the Pharmacy Director to the CEO and PI Director for reporting immediately to the governing body.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- The Performance Improvement dashboard and P&T committee meeting minutes will reflect aggregated count of medication errors.
- All Medication events will be reviewed and signed by both the chief nursing officer and the pharmacy director.
- All incidents and events will be reported in the PI Dashboard for review by the governing board on the monthly basis including recommendations by the PI committee.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address

			improvement in systems to prevent the likelihood of re-occurrence of the deficient practice: • All Medication events will be reviewed and signed by both the chief nursing officer and the pharmacy director. • Trends are identified by two or more incident occurring which were unintended and adverse errors. Once identified a plan of correction will be created by the CNO and coordination with the Director of Pharmacy. A plan of correction by the Director of Pharmacy and Chief Nursing officer will be submitted to the PI committee for approval by the governing board. • All incidents and events will be reported in the PI Dashboard for review by the governing board on the monthly basis including recommendations by the PI committee. **Individual Responsible:** Ryan Robertson, Director of PI and Risk. **Date Completed:** May 23, 2018	

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A 286	Continued From page 64 accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: . Based on interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to perform root cause analyses after adverse patient events and failed to track adverse drug events and assaults as part of their process improvement plan for patient safety. Failure to identify and analyze data to determine factors that contribute to patient injury can result in an unsafe healthcare environment. Findings included: 1. Document review of the hospital's policy titled, "Root Cause Analysis," (effective date 5/17) showed that the hospital defined "root cause analysis" as a process for identifying the basic or causal factors that underlies variation in performance including the occurrence or possible occurrence, of a sentinel event or "near miss", and defined "accident resulting in serious injury" as those serious physical injuries which result from accidents and which require a visit to an emergency room, medical center, or urgent care clinic and/or admission to a hospital. Document review of the hospital's policy titled, "Sentinel Event Reporting," (effective date 5/17) showed that sentinel event policy applies to events that meet criteria including suicide of a patient, even if the outcome was not death or permanent loss of function.	A 286		

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A 286	Continued From page 65 Document review of the hospital's Pharmacy and Therapeutics Committee Meeting minutes (dated 09/26/17)showed that the Chief Nursing Officer (Staff #407) reviewed medication errors and presented a summary of key findings from a task force meeting held earlier in the day. The minutes stated, "The majority of errors are attributable to after hours/floor stock drugs." Document review of the hospital's Pharmacy and Therapeutics Committee Meeting minutes (dated 01/17/18) showed that the minutes reflected that the data presented by pharmacy on medication errors may not match the data collected by the PI/Risk Director (Staff #405) for Q4, 2017, as pharmacy did not receive all the medication error reports. The minutes also stated the the PI/Risk Director will share the error reports through a weekly risk meeting. 2. On 03/08/15 at 10:48 AM, Surveyor #5 interviewed the Pharmacy Director (Staff #406) who stated that they started having weekly meetings to discuss the medication errors, but people didn't come so they haven't been occurring. She also stated currently there were no action plans or follow up on medication errors. 3. Surveyor #4 reviewed hospital incident reports filed between July 2017 and February 2018. During the months of December, January and February, the reports included the following incidents : a. A patient had a severe reaction to exposure to peanuts, requiring 2 doses of epinephrine and assistance from Emergency Medical Services b. In December, there were 4 of 5	A 286		

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A 286	Continued From page 66 patient-to-patient assaults that resulted in patient injury 4. During medical record review, Surveyor #5 identified 3 patients (#505, #506 and #508) with documented suicide attempts between January and February, 2018. One of 3 patients (#505) attempted suicide on two separate days during their admission (02/16/18 and 02/19/18). 5. On 03/08/17 beginning at 1:30 PM, Surveyor #4 interviewed the Director for Performance Improvement & Risk (Staff #405), regarding any root cause analyses that he completed related to any adverse patient events at the hospital. He stated that there had been no root cause analyses completed to date, because there had been no identified sentinel events. 6. On 03/15/18 between 10:00 and 11:30 AM, the survey team interviewed the hospital's governing body about how they receive information about patient safety incidents. Board members stated that they receive information about assaults through the monthly operating report. 7. On 03/15/18 at 10:30 AM, The Director of Process Improvement and Risk (Staff #405) presented the survey team with a copy ofthe monthly operating report (MOR). The report showed the following: a. Data collection between June 2017and January 2018 was only collected on total incidents b. The incident data was subdivided into Falls, Assault/Aggression, and Contraband, but only contained data for October 2017 through January	A 286		

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A 286	Continued From page 67 2018 c. Patient falls are included in the quality dashboard, but none of the data from the MOR appears in the current version of the quality dashboard d. Numbers for incidents, falls, assaults, and contraband are also expressed in rates per patient days and rates per 1000 patient days, but there is no evidence of analysis or tracking for trends. -At the time of the review, there was no evidence that data from the monthly operating report was integrated into the hospital's quality program. Cross Reference: Tag A0144, Tag 0396,	A 286		
A 297	QAPI PERFORMANCE IMPROVEMENT PROJECTS CFR(s): 482.21(d) As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations. (2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate	A 297	**Plan of Correction for Each specific deficiency Cited:** (A 297) The Hospital failed to: • Develop and implement performance improvement activities that supported hospital quality indicators related to patient safety and quality of care and failed to develop action plans to address identified areas of concern. • Develop projects and action plans based on results of data collection and aimed at improving patient outcomes puts patients at risk from	May 23,2018

harm due to
substandard care

Procedure/process for implementing the plan of correction:

The Performance improvement committee convened a meeting on 3/27/2018 with the directors of departments in order to initiate an updated dashboard that will review all required items to be communicated further to the governing body. The new dashboard will be approved at the next meeting and sent to the governing board for approval. This includes:

- A new study on patient outcomes (outcomes data will begin to be collected by 4/30/2018)
- Quality Improvement projects by each department and committee to be presented and approved first by Performance Improvement Committee then by the Governing board.
- Data, factors and recommendations by the PI Committee to the governing board on contributable patient injuries.
- Events adverse and sentinel
- Meeting Minutes will reflect review and any discussion in trends in reportable data and recommendations to the governing body.
- Meeting minutes will reflect any discussion in trend and whether a recommendation for a Quality Improvement plan is recommended to the governing body.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- A new dashboard is being created for governing body approval and will be sent for approval.
- The PI and Risk Director will report any negligent data to the CEO.
- Directors have approved to move forward on the new dashboard for governing body approval. Final draft will be approved at next Performance

			Improvement Committee. • The Dashboard document including meeting minutes will be sent to the governing board. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • The new approved dashboard and reports from committees will be communicated per policy to the governing board on a regular basis. • The dashboard will be sent to the governing board on a monthly basis. • Action levels and trends will depend on the review of the PI committee and the governing board for identified trends and events within the hospital. These identifications will be in the PI meeting minutes and sent to the governing board quarterly. **Individual Responsible:** Ryan Robertson, Director of PI and Risk **Date Completed:** May 23, 2018	

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A 297	Continued From page 68 measurable improvement in indicators related to health outcomes. (3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects. (4) A hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort. This STANDARD is not met as evidenced by: Based on interview, document review, and review of quality data, the hospital failed to develop and implement performance improvement activities that supported hospital quality indicators related to patient safety and quality of care and failed to develop action plans to address identified areas of concern. Failure to develop projects and action plans based on results of data collection and aimed at improving patient outcomes puts patients at risk from harm due to substandard care. Findings included: 1. Document review of the hospital's "Performance Improvement Dashboard" for2017 showed the following: a. The number of reported medication transcription variances had increased from 12in September 2017 to 60 in December2017. b. The percentage of staff who demonstrated the correct method of hand hygiene decreased from	A 297		

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A 297	Continued From page 69 94% in September 2017 to 54% in November 2017. 2. On 03/08/17 beginning at 1:30 PM, Surveyor #4 interviewed the Director of Performance Improvement and Risk (Staff #405), about any specific performance improvement projects related to the indicators. He was unable to identify any performance improvement projects tied to the indicators on the dashboard. 3. On 03/08/18 at 2:30 PM, Surveyor #4 asked the Infection Preventionist/Educator (Staff #404) about quality improvement projects related to hand hygiene. The staff member stated that there were no specific projects and that hand hygiene data collection continued to rely on in-person and video monitoring. 4. On 03/15/18 at 10:48 AM, Surveyor #5 interviewed the hospital Pharmacist (Staff #406). The staff member stated that she presents quarterly data to the Pharmacy and Therapeutics Committee, but that the data are not aggregated and there have been no action plans developed to address identified problems.	A 297	**Plan of Correction for Each specific deficiency Cited:** (A 308) The Hospital failed to: • Develop and implement performance improvement activities that supported hospital quality indicators related to patient safety and quality of care and failed to develop action plans to address identified areas of concern. • Develop projects and action plans based on results of data collection and aimed at improving patient outcomes puts patients at risk from harm due to substandard care	May 23,2018
A 308	QAPI GOVERNING BODY, STANDARD TAG CFR(s): 482.21 ... The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement) ... The hospital must maintain and demonstrate evidence of its QAPI program for	A 308	**Procedure/process for implementing the plan of correction:** The Performance improvement committee convened a meeting on 3/27/2018 with the directors of departments in order to initiate an updated dashboard that will review all required items to be communicated further to the governing body. The new dashboard will be approved at the next meeting and sent to the governing board for approval. This includes: • Aggregated data on patient outcomes	

(outcomes data will begin to be collected by 4/30/2018)

- Quality Improvement projects by each department and committee to be presented and approved first by Performance Improvement Committee then by the Governing board.
- Data, factors and recommendations by the PI Committee to the governing board on contributable patient injuries.
- Events adverse and sentinel
- Meeting Minutes will reflect review and any discussion in trends in reportable data and recommendations to the governing body.

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- A new dashboard is being created for governing body approval and will be sent for approval.
- The PI and Risk Director will report any negligent data to the CEO.
- Directors have approved to move forward on the new dashboard for governing body approval. Final draft will be approved at next Performance Improvement Committee.
- The PI Dashboard will be reviewed at the Medical Executive committee.
- The Dashboard document including meeting minutes will be sent to the governing board.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- The new approved dashboard and reports from committees will be communicated per policy to the governing board on a regular basis.
- The dashboard will be sent to the governing board on a monthly basis.

			• Meeting minutes will reflect that the medical executive committee will have reviewed the dashboard. **Individual Responsible:** Ryan Robertson, Director of PI and Risk **Date Completed:** May 23, 2018	

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A 308	Continued From page 70 review by CMS. This STANDARD is not met as evidenced by: Based on observation, interview and quality document review, the hospital failed to develop a hospital-wide plan to monitor, evaluate and improve the quality of patient care through data collection and analysis, development of quality improvement projects, and identification of risk factors for adverse patient outcomes. Failure to monitor the quality of patient care limits the hospital's ability to identify problems and create action plans that lead to sustained improvements in patient outcomes. Findings Included: 1. Document review of the hospital's Performance Improvement Dashboard for 2017 showed the following: a. The hospital identified 138 hospital-wide indicators. Of these, indicators for utilization management, social services, radiology, cardiology, lab services, outpatient, medical outpatient, dietary, human resources, finance, discharge summaries, seclusion, fall risk, and ligature risk had no entries beyond September 2017. b. There was no data collection related to seclusion for 7 of 7 seclusion indicators. There was also no data collection after September 2017 related to restraint use for 6 of 7 restraint indicators. There was no data collection after September 2017 related to patient falls.	A 308		

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A 308	Continued From page 71 2. Document review of the hospital's Medical Staff Bylaws, approved 04/17, showed that the Medical Staff are responsible for analysis of patient care processes and outcomes through a "valid and reliable quality managment program". 3. On 03/08/18, beginning at 1:30 PM, Surveyor #4 interviewed the hospital's Director for Performance Improvement & Risk (Staff #405) about the hospital's quality program data. The staff member stated that department directors are responsible for data submission to him, and acknowledged that there has been no consistent data collection since September, following his predecessor's departure. 4. On 3/12/18, at 3:55 PM, Surveyor #4 interviewed the acting Medical Director (Staff #401) who stated that she was new to the position and had not completed any practitioner reviews to date. Cross Reference: A0115, A0286, A0297, A0338	A 308		
A 338	MEDICAL STAFF CFR(s): 482.22 The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital. This CONDITION is not met as evidenced by: Based on interview and document review, the hospital failed to ensure that the medical staff operated in compliance with rules and by-laws	A 338	**Plan of Correction for Each specific deficiency Cited:** (A 338) The Hospital failed to operate in compliance with the hospital's rules and by-laws puts patients at risk of substandard care and adverse outcomes. **Procedure/process for implementing the plan of correction:** • The medical staff will review provider care through the OPPE/FPPE process as defined in the medical staff by-laws. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The medical executive committee will review the OPPE/FPPE's. The provider OPPE's/FPPE's will are reviewed for approval of privileges by the credentialing committee. • The governing board reviews all credentialing process's through review of the committee minutes and to the individual files. **Process improvement: Address process**	May 23,2018

			improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice: • Information will be discussed at: o Credentialing committee o Medical executive committee o Governing board. **Individual Responsible:** Medical Director **Date Completed:** May 23, 2018	

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SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

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A 338	Continued From page 72 approved by the governing body. Failure of the medical staff to operate in compliance with the hospital's rules and by-laws puts patients at risk of substandard care and adverse outcomes. Findings included: Failure to provide evidence of competency evaluations consistent with the Medical Staff By-Laws Failure to provide accountability to the governing body for the quality and appropriateness of medical care for hospital patients. Failure to complete and document a patient's History and Physical consistent with the hospital's Medical Staff Rules and Regulations. Due to the scope and severity of deficiencies identified under 42 CFR 482.22 Conditions of Participation for Medical Staff are NOTMET Cross Reference: Tags A0340, A0347, and A0358 .	A 338		
A 340	MEDICAL STAFF PERIODIC APPRAISALS CFR(s): 482.22(a)(1) The medical staff must periodically conduct appraisals of its members. This STANDARD is not met as evidenced by: . Based on interview and document review, the hospital failed to provide oversight and periodic	A 340	**Plan of Correction for Each specific deficiency Cited:** (A 340) The Hospital failed to operate in compliance with the hospital's rules and by-laws puts patients at risk of substandard care and adverse outcomes. **Procedure/process for implementing the plan of correction:** • The medical staff will review provider care through the OPPE/FPPE process as defined in the medical staff by-laws • The medical Director assigns a proctor to every provider on provisional status. • The proctor does report to the credentialing committee satisfactory completion of the provisional process prior to the credentialing committee granting active status. **Monitoring and Tracking procedures to ensure the plan of correction is effective:**	May 23,2018

			• The medical executive committee will review the OPPE/FPPE's. The provider OPPE's/FPPE's will are reviewed for approval of privileges by the credentialing committee. • The governing board reviews all credentialing process's through review of the committee minutes and to the individual files. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • Information will be discussed at: o Credentialing committee o Medical executive committee o Governing board. **Individual Responsible:** Medical Director **Date Completed:** May 23, 2018	

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A 340	Continued From page 73 review of the medical staff as required in their Medical Staff Bylaws. Failure to periodically review the competency and practice of privileged practitioners puts patients at risk of harm from substandard care. Findings included: 1. Document review of the hospital document titled, "Medical Staff Bylaws," section 6.62, adopted 4/2017, showed that practitioners on provisional status shall be proctored by one or more appropriate members as determined by the Medical Staff President for the number of cases or procedures specified by the Medical Staff President and that the proctor shall prepare a report with comments on the appointees performance. On 03/12/18 beginning at 3:55 PM, Surveyor #4 reviewed 10 provider credentialing files, including those of 4 mid-level providers. The review showed that 2 of the 4 mid-level providers, both Advanced Registered Nurse Practitioners (Staff #402 and Staff #403) appointed in October 2017, were identified as being in provisional status. The surveyor found no evidence of completed practice reviews in their files. 2. On 3/12/18, at 3:55 PM, Surveyor #4 interviewed the acting Medical Director (Staff #401) about completion of practice reviews for provisional staff. The Medical Director stated that she was new to the position and had not completed any reviews to date.	A 340		
A 347	MEDICAL STAFF ORGANIZATION &	A 347		

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A 347	Continued From page 74 ACCOUNTABILITY CFR(s): 482.22(b)(1), (2), (3) The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients. (1) The medical staff must be organized in a manner approved by the governing body. (2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy. (3) The responsibility for organization and conduct of the medical staff must be assigned only to one of the following: (i) An individual doctor of medicine or osteopathy. (ii) A doctor of dental surgery or dental medicine, when permitted by State law of the State in which the hospital is located. (iii) A doctor of podiatric medicine, when permitted by State law of the State in which the hospital is located. This STANDARD is not met as evidenced by: . Based on interview and review of Medical Staff Bylaws, and Medical Staff Rules and Regulations, the hospital's medical staff failed to carry out its functions consistent with the rules, regulations and bylaws approved by the governing body. Failure to adequately staff and structure the medical staff consistent with the policies and procedures approved by the governing body in	A 347	**Plan of Correction for Each specific deficiency Cited:** (A 347) The Hospital failed to **Procedure/process for implementing the plan of correction:** • The Medical Executive committee voted on the assignments of the President, Vice-President, and Secretary on 3/29/2018. • The MEC will assign a provider to each committee as per Section 11.3 and 11.4 of the Medical Staff By-laws and have it reflected in the minutes. • Meeting minutes will be reported to the Governing board at a minimum of quarterly. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Meeting minutes will be reported to the governing body at minimum of quarterly. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • The Medical Director will ensure that the MEC is scheduled on a regular basis as approved by the MEC.	May 23,2018

			Individual Responsible: Medical Director **Date Completed:** May 23, 2018	

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A 347	Continued From page 75	A 347		

the Medical Staff Bylaws, puts patients at risk of substandard care and adverse outcomes.

Findings included:

1. Document review of the hospital's document titled," Medical Staff Bylaws Smokey Point Behavioral Hospital," (approved 05/30/17) showed that article 11.2 of the bylaws describes the composition of the Medical Executive Committee (MEC) as having a President, Vice-President, and Secretary-Treasurer, who are all active members of the medical staff, and will also include the Chief Executive Officer as an ex-officio member.

The duties of the MEC will include recommending to the board all manner of appointments, reappointments and staff membership, and will also account to the board and to the staff for the overall quality of care rendered to patients.

Section 11.3 and 11.4 of the Medical Staff Bylaws showed that the MEC shall assign staff functions to include: Quality Management, Credentials Review, Continuing Education, Bylaws, Rules and Regulations, Treatment Plan and Medical Record Review, Utilization Review, Pharmacy and Therapeutics, Infection Control, Risk Management and Patient Safety, Therapeutic Environment and Safety Function, Grievance Committee, and Practitioner Health. Provisions for staffing of these committee functions shall be either through staff assignment or through the MEC itself.

2. On 03/12/18 at 3:55 PM, Surveyor #4 interviewed the Medical Director (Staff #401) about the makeup of the Medical Executive

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A 347	Continued From page 76 Committee and how it functions at the hospital. She stated that there were not enough physicians to have a medical executive committee. At the time of the interview, there were 2 full time physicians including the Medical Director, 1 part-time physician and 1 locums physician. 3. On 03/15/18 between 10:00 and 11:30 AM, the survey team interviewed the hospital's governing body, including the hospital's Medical Director (Staff #401) about how the governing body receives information about patient safety and the overall operation of the hospital. Members of the governing body stated that their monitoring is multidimensional and includes review of all meeting minutes and that staff members make presentations at various times in the facility. Surveyor #4 asked if the governing body had evidence that the Medical Director directly interacted with the board regarding the medical care of patients. The board members indicated that there were discussions with the Medical Director, but there was no documentation in the minutes to reflect the topics or the scope of those discussions. Cross Reference: Tag 0049	A 347	**Plan of Correction for Each specific deficiency Cited:** (A 358) The Hospital failed to: • Ensure the physical (H&P) for each patient was completed within 24 hours after hospital admission. **Procedure/process for implementing the plan of correction:** • Primary Care providers re-educated on policy of completing H&P within 24 hours of admission. • Re-education by email will be conducted. All primary staff will sign acknowledgement by May 23, 2018	May 23,2018
A 358	MEDICAL STAFF RESPONSIBILITIES CFR(s): 482.22(c)(5)(i) [The bylaws must:] Include a requirement that-- (i) A medical history and physical examination be completed and documented for each patient no	A 358	**Monitoring and Tracking procedures to ensure the plan of correction is effective:** • 15% of the medical records will be audited five times a week. Auditing will continue until 100% compliance for one month. If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100%	

			compliance is reached for 1 continuous month then spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported to the Medical Director for follow up and report to the Medical Executive committee. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • Data and findings will be reported to the PI Committee on a monthly basis until100% compliance is achieved for one continuous month. **Individual Responsible:** Dr. Elina Durchman, MD **Date Completed:** May 23, 2018	

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A 358	Continued From page 77 more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified individual in accordance with State law and hospital policy. This STANDARD is not met as evidenced by: . Based on policy review and review of medical records, the hospital failed to ensure that medical providers completed and documented a History and Physical (H&P) for each patient within 24 hours after hospital admission. . Failure to conduct an assessment on all patients at admission puts patients at risk of an adverse outcome in the event that the patient's medical condition require alteration of the treatment plan. Findings included: 1. Document review of the hospital's Medical Staff Rules and Regulations (04/17) showedthat a H&P is to be completed within 24 hours of admission and if patient is a readmission and the H&P was performed within 30 days, then an update is needed. 2. Surveyor #9 reviewed the medical record of Patient # 908 who was admitted to the hospital on 02/17/18. The patient had been previously admitted to the hospital two weeks earlier. There was no H&P or update of an H&P from a previous admission included in the patient's record.	A 358		

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A 358	Continued From page 78	A 358		
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to ensure sufficient numbers of nursing staff were available to provide safe and effective care for patient's health care needs. Failure to provide enough staff to meet patient needs risks deterioration of the patient's health status and delayed treatment. Findings included: Failure to ensure that the number of assigned personnel allows for treatment planning and delivery of care as ordered by the treatment team; Failure to ensure that staff members followed standards of practice and hospital policy and procedure for patient identification prior to administration of medications. Failure to ensure that staff members followed hospital policy and procedure for transcription and verification of physician orders. Due to the scope and severity of deficiencies	A 385	**Plan of Correction for Each specific deficiency Cited:** (A 385) The Hospital failed to ensure that • staff members allowed treatment • Follow procedure on patient identification • Transcription and verification of physician orders. **Procedure/process for implementing the plan of correction:** • Treatment team will complete treatment planning process on every patient per the treatment planning standards. This includes ensuring the treatment plan is completed in 72 hours and reviewed at minimum weekly and updated daily accordingly. • Staffing patterns are developed. Staffing minimums are based on the department heads evaluation of needs of acuity, census, and time allotment to perform job duties. • The treatment plan will be completed by the responsible party and documented accordingly. • Nurses will be re-educated on 2 patient identifiers, by picture or patient has to show armband, and asking the patient's date of birth.	May 23,2018

Monitoring and Tracking procedures to ensure the plan of correction is effective:

- The nurse management will randomly review/audit a medication pass per unit once a week and report the findings to the CNO,until 100% compliance has been reached for one continuous month.
- After one month of 100% compliance for patient identifiers the Nurse management will audit a unit once per month during a monthly educational rounding/review/audit.
- The CNO actively assess the staffing pattern and need for additional four times a day.
- Should additional staff be required in order to adequately address treatment needs. Staff will be obtained through.
    - The PRN pool
    - Overtime for employees
    - Agency utilization
    - Should no staff be able to be obtained all admissions to the unit will be delayed until additional staff can be obtained.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Audit data will be reported in the Performance improvement committee until 100% compliance has been achieved.

Individual Responsible:
John Beall, CNO
Date Completed:

May 23, 2018

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A 385	Continued From page 79 cited under 42 CFR 482.23, the Condition of Participation for Nursing Services was NOT MET. Cross Reference: Tags A0144, A0392, A0395, A0396, A0405, A467	A 385		
A 392	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b) The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: . Based on document reviews and interviews, the hospital failed to ensure the facility had sufficient nursing personnel to provide safe and effective care to patients. Failure to provide an adequate number of trained registered nurses (RN), licensed practical nurses (LPN), and mental health technicians (MHT) risks patient safety and delays in care and treatment. Findings included: 1. Document review of the hospital document titled, "Nurse Staffing Plan," dated 05/17, showed that nursing care is to be provided by sufficient numbers of nursing staff members including registered nurses and licensed practical nurses to meet the identified nursing care needs of patient	A 392	**Plan of Correction for Each specific deficiency Cited:** (A 392) The Hospital failed to provide an adequate number of trained RN's, LPN's, and MHT's. **Procedure/process for implementing the plan of correction:** • There will be at minimum one RN per each unit per shift. • When an position becomes open the position will be filled by fulltime staff, part, per diem staff, or agency. • The staffing grid identifies whether an RN, LPN, or tech is required. • The charge nurse is required to be an RN and choosing the RN by the CNO it is, taken into consideration the specific nurses training and expertise and knowledge of the specific patient population. • A bonus is being offered for any staff referring a nurse that has been hired. • All nurses are offered free insurance for full time employment. • Salaries have been adjusted to be highly competitive in the area. • The grid has been adjusted per nursing suggestions. • Contacts have been signed to allow for	May 23,2018

			staffing agencies. • Traveling nurses have been obtained to fill vacancies. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • CNO will report to CEO of staffing during the daily management meeting. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • CNO will track staffing and report CEO. **Individual Responsible:** John Beall, CNO **Date Completed:** May 23, 2018	

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A 392	Continued From page 80 and family members twenty-four hours a day. Core staffing is based on the following critical factors: - Patient characteristics - The number of patients receiving care, including admissions, discharges and transfers - Intensity of patient care being provided - The variability of patient care across the unit -The scope of services provided, accounting for architecture and geography of the unit -The staff characteristics, including staff consistency, tenure, experience - The number and competencies of both clinical and non-clinical support staff the nurse must collaborate or supervise. 2. On 03/14/18 at 2:40 PM, Surveyor #3 reviewed the hospital nurse-staffing grid that was approved by the chief nursing officer on 03/09/18. The nurse-staffing grid was organized by clinical unit and patient census. Unit staffing was divided into two types of personnel: "nurses" and mental health technicians. The surveyor could not find any differentiation made on the staffing grid regarding the type of nurse required to staff the unit. The grid did not specify use of either a registered nurse or a licensed practical nurse. 3. A review of the daily staffing sheet utilized by the nursing supervisor for a seven-day period (01/28/18 - 02/03/18) revealed the following: a. The adolescent inpatient unit 1-East, which cares for children ages 12 to 17, did not have a registered nurse assigned to the night shift for 1 of 7 days reviewed. b. The adult geriatric unit 1-West, which cares for	A 392		

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A 392	Continued From page 81 adults 55 and older did not have a registered nurse assigned to the night shift for 5 of 7 days, reviewed which included 4 consecutive nights. c. The adult unit 2-West which cares for adults 18 years and older with chronic mental illness did not have a registered nurse assigned to the day shift for 2 consecutive days and 1 of 7 night shifts. d. The adult unit 2-East which cares for adults 18 years and older with mood disorders did not have a registered nurse assigned to the night shift for 2 of 7 days reviewed. e. The adult unit 2-North which cares for adults 18 years and older with acute mental illnesses to include psychosis did not have any licensed nursing staff (either an RN or LPN) assigned for one night shift. The unit did not have a registered nurse assigned for 1 of 7 day shifts and 2 of 7 night shifts. 4. A review of the daily staffing sheet utilized by the nursing supervisor for three 3-day periods (02/16/18 - 02/18/18; 02/17/18 - 03/01/18; 03/09/18 - 03/11/18) revealed the following: a. The adult geriatric unit 1-West, which cares for adults 55 and older did not have a registered nurse assigned to the night shift for 5 of 9 days reviewed, leaving the unit with a singular licensed practical nurse in attendance. In addition, the review showed that the unit had two 24-hour periods of the nine days analyzed in which no registered nurse was assigned. b. The adult unit 2-West which cares for adults 18 years and older with chronic mental illness did not have a registered nurse assigned to the unit for a	A 392		

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A 392	Continued From page 82 24-hour period. The review also showed two consecutive day shifts where no registered nurse was assigned. c. The adult unit 1-North, which cares for active duty military and veterans, did not have a registered nurse assigned for 6 out of 6 night shifts reviewed. d. The adult unit 2-North which cares for adults 18 years and older with acute mental illnesses to include psychosis, did not have a registered nurse assigned for a 36-hour consecutive period. 5. On 03/14/18 at 2:50 PM, Surveyor #3 interviewed Staff #301 about the daily staffing sheet utilized by the nursing supervisor. She verified and confirmed the findings described above. 6. On 03/06/18 at 2:25 PM, Surveyor #11 interviewed a physician (Staff #306) regarding staffing on the older adult unit 1-East. He stated that staffing on the floor is not adequate when there is only one nurse to eleven patients. Staff #306 stated the nurse would have to do everything including rounding, administering medications, and addressing all of the patient needs. He indicated that when the acuity (intensity of need for care or monitoring) goes up, such as when patients require 1:1 monitoring, the hospital needs to increase the number of staff on the unit. 7. On 03/05/18 at 1:40 PM, Surveyor #5 interviewed the charge nurse (Staff #502) on 2-North about the unit and its patients. Staff #502 indicated he was a new nursing graduate and today was his first day off orientation. The	A 392		

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A 392	Continued From page 83 surveyor asked Staff #502 if any of the patients were on special precautions such as line-of-sight monitoring or suicide precautions. He stated that he was unaware of any patient being on that status. A review of the patient charts on the unit revealed that two patients were on line-of-sight monitoring and one patient was on both fall and suicide precautions. The surveyor observed Staff #502 had difficulty navigating the medical record to locate requested documents. Staff #502 was unaware of which patients on the unit were there for involuntary treatment. 8. On 03/06/18 at 11:43 AM, Surveyor #5 interviewed a MHT (Staff #516) about her job duties. During the interview, Staff #516 stated that one of her roles is to lead groups. She also stated that because there is not enough staff, groups sometimes do not get done or she has to leave the group to do the 15-minute patient checks. Staff #516 stated because of this, she feels her groups are not as effective. 9. On 03/07/18 at 8:00 AM, Surveyor #11 interviewed a registered nurse (Staff #302) about staffing. The nurse stated that the nursing unit 2-East usually has 25 or more patients on it and is never staffed appropriately. She indicated that the hospital leadership never provides more than four staff members per shift even when there are patients who required one to one or line of sight monitoring. Staff #302 stated if there are only two staff members on a unit, it is very difficult to run the unit given all of the duties and responsibilities required of the staff to perform. She confirmed that this happens almost every day somewhere in the hospital with the night shift being very short staffed overall.	A 392		

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A 392	Continued From page 84 10. On 03/07/18 at 11:38 AM, Surveyor #5 interviewed a MHT (Staff #517) about her job duties. During the interview, Staff #517 stated that she has to run four groups during her shift. She stated that sometimes she has to stop group so she can go do her rounds on patients who do not participate. She acknowledged leaving intermittently affects the success of the group . 11. On 03/07/18 at 12:05 PM, Surveyor #5 interviewed a charge nurse (Staff #508) about maintaining a safe environment for patients. During the interview, Staff #508 stated that on 02/17/18 three patients tried to commit suicide on the unit 2-East. She stated that there was not enough staff to monitor the patients, and they were unable to find enough staff to come into work so they locked all the patients out of their rooms so they could be watched for their safety. 12. On 03/07/18 at 2:50 PM, Surveyor #11 interviewed the Chief Nursing Officer (CNO) (Staff #307) about nurse staffing for the hospital. He stated that he met last Thursday (03/01/18) with some nurses about their staffing concerns . Hospital leadership approved a staffing grid that included 5 more full time nursing positions. The CNO stated that when the hospital was first opened, they were "rich" in staffing. By fall of last year, as time went by and the staff gained experience, corporate leadership asked him to be within budget. The CNO indicated that every nursing unit has a nurse that works every shift. He acknowledged there are more LPN's than RN's currently working. The CNO confirmed that there is no policy that delineates the roles and responsibilities of the RN versus the role and responsibilities of the LPN.	A 392		

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A 392	Continued From page 85 13. On 03/08/17 at 10:10 AM, Surveyors #4 and #5 presented to unit 2-West and asked the RN (Staff #512) standing at the nurse's station if they could speak with the charge nurse. The nurse became flustered and began looking through paperwork to determine which charge nurse was assigned to the unit for the day. When Staff #512 was unable to determine who the charge nurse was, she stated, "We have 2 nurses pick one." Surveyor #5 observed that Staff #512 was the only RN on the floor and the other nurse (Staff #518) was an LPN. 14. Review of the hospital grievance log between June 2017 and March 2018, showed that in December 2017, patients' family members or friends filed 10 grievances related to reduction of stated visitation hours. In five of those grievances, the complainants reported the hospital staff cited short staffing as the reason for curtailing patient visitation hours. Cross Reference: Tags A0144, A0166, A0395, A0396, A0405, A0467	A 392	**Plan of Correction for Each specific deficiency Cited:** (A 395) The Hospital failed to ensure that a registered nurse (RN) signed off on an initial nursing assessment and treatment plan completed by a Licensed Practical Nurse (LPN) for 1 of 1 record reviewed **Procedure/process for implementing the plan of correction:** Nurses were re-educated on proper procedure that an RN must complete and sign off on the initial nursing assessment and treatment plan and not an LPN. Written documentation and post test were used by the CNO for education. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • 15% of the medical records will be audited five times a week. Auditing will continue until 100% compliance for one month to ensure that an RN has signed off on the initial nursing assessment and treatment plan vs. an LPN.. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address**	May 23,2018
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on record review and review of the hospital's policy and procedures, the hospital failed to ensure that a registered nurse (RN) signed off on an initial nursing assessment and	A 395		

			improvement in systems to prevent the likelihood of re-occurrence of the deficient practice: • The data collected from the audit will be reported to the PI committee monthly until 100% compliance has been reached for one continuous month. **Individual Responsible:** John Beall, Chief Nursing Officer **Date Completed:** May 23, 2018	

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A 395	Continued From page 86 treatment plan completed by a Licensed Practical Nurse (LPN) for 1 of 1 record reviewed (Patient #907). Failure of the RN to review an initial assessment and treatment plan could lead to patient harm if physical or psychological conditions are not identified. Findings included: 1. Document review of the hospital's policy and procedure titled, "Treatment Planning," effective 05/17, showed that the RN will add any medical problems to be addressed to the treatment plan and discussed with the patient/family. Additionally, any emergency precautions are to be included in the initial treatment plan. 2. Surveyor #9 reviewed the medical records of patient #907, which showed that the initial nursing assessment and initial treatment plan was conducted by and signed off by a LPN. The RN did not co-sign the initial nursing assessment or the initial treatment plan.	A 395	**Plan of Correction for Each specific deficiency Cited:** (A 396) The Hospital failed to develop care plans to address patient care may lead to patient harm and failure to appropriately treat a medical condition **Procedure/process for implementing the plan of correction:** • All RN's and LPN's were re-educated on ensuring that the medical problem is included in the treatment plan. • All RN's and LPN's were re-educated on ensuring that all precautions ordered are also addressed in the treatment plan. • All RN's and LPN's nurses were re-educated on updating the treatment plan for any events of seclusion or restraint. • Documentation will be audited on a daily basis to ensure timeliness, completion and accuracy of the initial treatment plan including medical condition.	May 23,2018
A 396	NURSING CARE PLAN CFR(s): 482.23(b)(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: ITEM #1 - Treatment Plans/Care Plans	A 396		

- All RN's was re-educated on proper consultation referrals and will ensure that they are conducted.
- Re-training was provided to all Clinical Services Staff which is our program therapists involved with treatment planning on 3.27.2018. Training focused on required timelines for completion of the Master Treatment Plan, where to collect data to determine any Special Precaution levels, such as: Seclusion & Restraint, Suicide, Assault, and or Fall. Also each Master Treatment Plan must be individualized and identify problems specific to each to address as part of the course of treatment.

- All RN staff were re-educated by the CNO to complete nutritional screening in the nursing assessment and when indicated will complete a referral to the dietician for evaluation of nutritional deficiencies. This includes but is not limited to:

- -Poor appetite
- -Diabetes
- -Underweight
- -Chronic constipation
- -Medical condition that requires nutritional intervention
- -On medications that may interact with foods
- -Taking nutritional supplements at home
- -Lactose intolerant
- -Pregnant-History of eating disorder
- -Obese
- -Signs of malnutrition Unplanned weight gain or loss
- -Chewing, swallowing problems

			• -History of chronic dieting • -Nausea and vomiting more than 3 days **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • 15% of treatment plans in the medical records will be audited for completeness five times a week. Auditing will continue until 100% compliance for one month. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • Data collected by the audit will be reported to the PI committee monthly until 100% compliance is reached for one continuous month. **Individual Responsible:** John Beall, Chief Nursing Officer **Date Completed:** May 23, 2018	

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A 396	Continued From page 87 Based on review of hospital policies and procedures and review of medical records, the hospital failed to ensure that staff developed , initiated, and updated patient care plans for 8 of 8 patients (Patient #906, #501, #504, #505, #522, #525, #526, and 1101). Failure to develop care plans to address patient care may lead to patient harm and failure to appropriately treat a medical condition. Findings included: 1. Document review of the hospital's policy titled, "Treatment Planning," effective 05/17, showed that the registered nurse (RN) should add any medical problems to be addressed in the treatment plan. Document review of the hospital's policy and procedure titled, "Medical Staff: Treatment Planning," effective date 04/17, showed that an initial plan of care will be documented within 24 hours of admission by the admitting nurse and focus on safety, diagnostics and patient centered goal setting. The multidisciplinary team will prepare the Master Treatment plan within 72 hours of admission and will establish goals in reference to specified problems. Document review of the hospital's policy and procedure titled, "Precaution: Suicide," effective date 05/07, showed that patients placed on suicide precautions must have a safety plan in the Master Treatment Plan. Document review of the hospital's policy and procedure titled, "Use of Seclusion," effective date 05/17, showed that patients placed in	A 396		

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A 396	Continued From page 88 seclusion must have seclusion added to the Master Treatment Plan. Document review of the hospital's policy and procedure titled, "Use of Restraints," effective date 05/17, showed that the treatment plan for patients requiring restraint should be reviewed and amended following the first episode of restraint to include measures to prevent reoccurrence. Document review of the hospital's policy and procedure titled, "Precautions: Assault/Homicidal Risk," effective date 05/17, showed that patients placed on assault or homicide precautions must have a safety plan added to the Master Treatment Plan. Document review of the hospital's policy and procedure titled, "Fall Prevention Program Guidelines," effective date 05/17, showed that when patients are assessed at high risk for fall, the treatment plan will identify any and all individualized interventions to prevent falls. 2. Surveyor #9 reviewed the medical record of Patient #906, an insulin dependent diabetic admitted to the hospital on 02/26/18. A review of the nursing treatment plan revealed no planning related to diabetes treatment, including insulin dosing and blood glucose monitoring. 3. On 03/05/18 at 2:10 PM, Surveyor #5 reviewed the medical record of Patient #501 who was admitted on 02/24/18 for stabilization and treatment of continuing suicidal ideation (SI) with intention to harm herself. The patient's previous diagnosis included:	A 396		

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A 396	Continued From page 89 -Bipolar disorder -Self-injurious behavior by cutting herself -Auditory hallucinations -A history of three suicide attempts -An attempt to choke herself on a previous admission to the hospital The medical record review showed the following: On 02/25/18 at 1:45 AM, the patient was assessed at high risk for suicide and placed on suicide precautions. Surveyor #5 found no evidence that staff had added safety precautions for suicide or self-harm to the Master Treatment Plan. On 03/03/18 at 4:40 PM, a nursing note showed that the patient assaulted multiple staff members and was moved to the 2-North unit. Surveyor #5 found no evidence that the Master Treatment Plan included a safety plan for assault precaution. On 03/03/18 at 5:30 PM, the daily nursing assessment for suicidal ideation documentation showed that "attempted" and "actively endorsed" were both circled in the suicide assessment. Surveyor #5 found no evidence that the Master Treatment Plan included a safety plan addendum for suicide precaution. 4. On 03/06/18, Survey #5 reviewed the discharge medical record of Patient #505 who was admitted on 02/10/18, following a suicide attempt made 24 hours prior to admission to the hospital. The medical record review showed the following: On 02/10/18 at 4:30 PM, an admitting provider wrote an order to place the patient on suicide	A 396		

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precautions and self-harm precautions with close observation and 15-minute checks. Surveyor #5 found no evidence of a safety plan for suicide in the Master Treatment Plan.

On 02/12/18 at 1:06 PM, a provider wrote an order to discontinue all unit restrictions. The patient observation record showed that the patient was removed from suicide precautions but remained on self-harm precautions and was checked every 15 minutes. Four days later, on 02/16/18, the patient attempted suicide by hanging himself with his bedsheets and was transported to an Emergency Department at a medical hospital. Surveyor #5 found no evidence that a safety plan was added to the Master Treatment Plan.

On 02/19/18 at 11:30 AM, a nursing note showed that the patient made a second suicide attempt. The Hospital staff found the patient down with a blue blanket around his neck. Surveyor #5 found no evidence of a safety plan for suicide prevention in the Master Treatment Plan.

5. On 03/09/18 at 8:30 AM, Surveyor #5 reviewed the discharged medical record for Patient #525 who was admitted on 01/24/18 for the treatment of suicidal ideation that included a plan to kill himself. The medical record review showed the following:

The Emergency Department provider notes dated 01/23/18 at 5:51 PM showed that the patient's medical history included:

-Spina bifida (a spinal birth defect)
-A neurogenic bladder (dysfunction of the urinary bladder due to disease of the central nervous

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A 396	Continued From page 91 system or peripheral nerves involved in the control of urination) -An elevated white blood cell count -A urinary tract infection -Wheelchair bound -Has an anaphylactic allergy to peanuts On 01/24/18 at 5:30 PM, the Initial Nursing Assessment showed that the patient had an anaphylactic allergy to peanut butter, was in a wheelchair, and had stiff knees. The patient was assessed at low risk for a fall, On 01/25/18, the patient's Master Treatment plan showed two psychiatric problems including anxiety and depression. The Master Treatment Plan listed no medical problems. An update on 02/04/18 shows no changes to the treatment plan. Surveyor #5 found no evidence that thestaff addressed medical problems including disability with lower extremity weakness affecting mobility and requiring a wheelchair, self-catheterization for neurogenic bladder, a bowel program, or an anaphylactic allergy to peanuts in the Master Treatment Plan. 6. On 03/12/18, Surveyor #5 reviewed the medical record of Patient #504, who was admitted on 02/06/18 for treatment of Psychosis, Suicidal Ideation, Command Auditory Hallucinations to harm self, Audio, Visual and Tactile Hallucinations, poor sleep and poor appetite. The medical record review showed the patient was a diabetic and taking metformin (a medication used to treat patients with Type 2 Diabetes). Surveyor #5 found no evidence that staff had addressed the patient's diabetes treatment, including metformin dosing and blood glucose monitoring, in the Master Treatment	A 396		

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Plan.

7. On 03/13/18 at 1:58 PM, Surveyor #5 reviewed the medical record for Patient #526, who had been admitted on 03/12/18. The medical record review showed that the patient had fallen the night before and hit his head and was subsequently transferred to an Emergency Department at a medical hospital. Surveyor #5 found no evidence the treatment plan identified individualized interventions to prevent falls.

At the time of the review, Surveyor #5 observed Patient #526 sitting halfway down in a chair with only regular socks on his feet.

8. On 03/14/18 at 9:45 AM, Surveyor #5 and a Registered Nurse (Staff #513) reviewed the medical record of Patient #522 who was admitted on 02/11/18 for the treatment of Schizophrenia, Audio and Visual Hallucinations and Paranoid Delusions. The record review showed the following:

On 02/11/18 at 5:10 AM, a provider wrote an order to place the patient on assault/homicidal precautions with close observation and 15-minute checks. Surveyor #5 found no evidence that staff addressed a safety plan for assault/homicidal precautions in the Master Treatment Plan.

On 02/17/18 at 3:30 AM, a Registered Nurse progress note showed that the patient was agitated because she did not like her roommate. The patient assaulted her roommate by pushing her on two occasions, first at 2:00 AM, and again at 2:30 AM. Surveyor #5 found no evidence that staff addressed a safety plan for assault/homicidal precautions in the Master

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A 396	Continued From page 93 Treatment Plan. On 02/18/18 at 11:00 PM, a provider wrote an order for the patient to be on Assault Precautions due to aggressive assault on staff. Surveyor #5 found no evidence that staff included or updated the Master Treatment Plan to include a safety plan. On 02/19/18 at 6:00 AM, a Registered Nurse progress note showed that the patient was verbally aggressive, threatening patients and staff, and assaultive toward staff. Staff placed the patient in seclusion and gave the patient medications. Surveyor #5 found no evidence that staff added the patient's seclusion to the Master Treatment Plan. On 02/21/18, 02/24/18, and 02/25/18, the patient demonstrated continued assaultive behavior on staff and peers. Surveyor #5 found no evidence that staff added a safety plan for assault/homicidal precautions to the Master Treatment Plan. 9. On 01/26/18 at 11:00 PM, Patient #1101 was readmitted to the psychiatric hospital for psychiatric care following discharge from a medical center where the patient received care for cellulitis and diabetic ulcers on the right great toe and 2nd toe. The Master Treatment Plan showed that the patient's active medical problem list included diabetes and hypertension but did not include the patient's diagnoses of cellulitis [skin infection] and diabetic ulcers on his toes. There was no nursing care plan in the patient's medical record to guide nursing staff in the care of a patient with a wound. Review of the patient's discharge medical record showed the following:	A 396		

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A 396	Continued From page 94 The Nursing Initial Assessment completed on 01/26/18 at 11:00 PM, stated that the right second toe was an open wound and that it was red and swollen with a dressing cover. The nurse documented that the patient had right foot pain. On 01/27/18 at 8:30 AM, a medical consultant (Staff #1105) completed the patient's history and physical. The history and physical examination showed that the patient had cellulitis and a diabetic foot ulcer. On 03/09/18 at 10:00 AM, Surveyor #11 interviewed the Chief Nursing Officer (Staff #1102) about the Master Treatment Plan and Problem List for Patient #1101. The Chief Nursing Officer acknowledged that the Master Treatment Plan did not include the patient's wound or cellulitis and that there was no nursing care plan in the patient's medical record. ITEM #2- Nutritional Screening Based on review of hospital policies and procedure and review of medical records, the hospital failed to ensure that staff referred a patient for a nutritional consult with a dietician for evaluation of nutritional deficiencies. Failure to refer a patient for a nutritional consult may lead to poor nutrition and poor health outcomes. Findings included: 1. Document review of the hospital's form titled, "Nutritional Screen," showed that patients were to	A 396		

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A 396	Continued From page 95 receive a referral for a nutritional consult when any of the referenced conditions were identified in a patient's screening. This included: . -Poor appetite -Diabetes -Underweight -Chronic constipation -Medical condition that requires nutritional intervention -On medications that may interact with foods -Taking nutritional supplements at home -Lactose intolerant -Pregnant-History of eating disorder -Obese -Signs of malnutrition Unplanned weight gain or loss -Chewing, swallowing problems -History of chronic dieting -Nausea and vomiting more than 3 days . 2. Surveyor #9 reviewed the medical record of patient #911, whose nutritional screening showed that the patient had a poor appetite and was taking nutritional supplements at home; however, there was no evidence in the patient's record that staff requested a nutritional consult. 3. On 03/12/18, Surveyor #5 reviewed the medical record of Patient #504 who was admitted on 02/06/18 for treatment of Psychosis, Suicidal Ideation, Command Auditory Hallucinations to harm self, Audio, Visual and Tactile Hallucinations, poor sleep and poor appetite. The medical record review showed the patient was a diabetic and taking metformin (a medication used to treat patients with Type 2 Diabetes). The patient's nutritional screen on admission showed the patient is a Diabetic, which required a referral	A 396		

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A 396	Continued From page 96 for a Nutrition consult. Surveyor #5 found no evidence staff requested a Nutritional consult for the patient. Cross Reference: Tag A0068	A 396		
A 405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Item #1- Patient Identification Based on observation, interview, and document review, the hospital failed to ensure all hospital staff members followed its procedure for	A 405	**Plan of Correction for Each specific deficiency Cited:** (A 405) The Hospital failed to use two patient identifiers prior to administration of medications. **Procedure/process for implementing the plan of correction:** • Nurses were re-educated on hospital identifiers on 4/18/2018. • Nurses were re-educated on timeliness of transcribing orders. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • The nurse management will randomly review/audit a medication pass per unit once a week and report the findings to the CNO, until100% compliance has been reached for one continuous month. • Nurse managers will audit timeliness and accuracy of transcribed orders. All records will be audited on a daily basis until 100% compliance is reached for one continuous month. • After one month of 100% compliance the nursing educator will audit a unit once per month during a monthly educational rounding/review/audit. **Process improvement: Address process improvement and demonstrate how the**	May 23,2018

			facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice: • Audit findings/data will be reported to the P&T committee monthly. Minutes and data will be reported also to the PI committee monthly. **Individual Responsible:** John Beall, Chief Nursing Officer **Date Completed:** May 23, 2018	

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A 405	Continued From page 97	A 405		

identification of patients prior to medication administration, as demonstrated by 4 of 4 patients observed (Patients #301, #302, #520, #521).

Failure to follow the hospital's patient identification process places patients at risk for medication errors and patient harm.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Patient Identifiers," no policy number, effective 05/17, showed that when administering medications, the staff will use two patient identifiers. The hospital's approved patient identifiers are the patient's picture, the patient's name as given by the patient with an alternate identifier being the patient birth date.

2. On 03/12/18 at 2:20 PM, Surveyor #3 observed a medication administration for two patients (Patient #301, #302). The observation showed that the licensed practical nurse (Staff #304) failed to use two patient identifiers prior to administering their medication. In both cases, the staff member called the patients by their first name, rather than asking them to state their name or use another identifier.

When asked by Surveyor #3 why she failed to use two patient identifiers, Staff #304 indicated that she knew the patients and could always check the picture or ask them their room number if she had questions.

3. On 03/13/18 from 9:14 to 9:20 AM, Surveyor #5 observed medication administration for two patients (Patient #520, #521). The registered

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A 405	Continued From page 98 nurse (Staff #512) failed to use two patient identifiers prior to administering the medications. 4. Following the medication administration, Surveyor #5 interviewed Staff #512 about the hospital's policy and procedure for patient identification. The nurse stated, "We don't spend a lot of time on patient identification, I've been working here for three weeks, it's not pure policy." Item #2- Transcribing to the Medication Administration Record Based on document review and review of hospital policy and procedures, the hospital staff failed to follow its procedure for transcribing and verifying physician orders to the medication administration record for 5 of 5 patient records reviewed (Patient #303, #304, #305, #306, and #307). Failure to transcribe and process physician orders correctly places patients at risk for medication errors and patient harm. Findings included: 1. Document review of the hospital's policy and procedure titled, "Physician Orders," no policy number, effective 05/17, showed that the nurse will transcribe medication and treatment orders. Any medication order transcribed to the medication administration record (MAR) is to be checked for accuracy by a second nurse during the chart check (at shift change and 24-hour chart check). 2. On 03/13/18 at 11:30 AM, Surveyor #3 reviewed the MAR for five patients and noted the following:	A 405		

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A 405	Continued From page 99 a. Patient #303 was admitted on 03/02/18 and had 8 medication orders not verified by a second nurse at shift change. b. Patient #304 was admitted on 03/01/18 and had 20 medication orders not verified by a second nurse at shift change. c. Patient #305 was admitted on 03/01/18 and had 9 medication orders not verified by a second nurse at shift change. d. Patient #306 was admitted on 03/03/18 and had 8 medication orders not verified by a second nurse at shift change. e. Patient #307 was admitted on 03/09/18 and had 3 medication orders not verified by a second nurse at shift change. 3. On 03/13/18 at 12:30 PM, Surveyor #11 reviewed the medical record of Patient #308. The review showed that a medication order for magnesium citrate 300 ml (a laxative) was transcribed incorrectly to the MAR as magnesium citrate 150 ml. No initials were present to indicate who had transcribed the order to the MAR and no initials were present to verify the physician order had been transcribed correctly. The surveyor asked the nurse (Staff #305) which staff member transcribed the order to the MAR. Staff #305 stated that the hospital unit clerk (Staff #308) transcribed the order. The nurse acknowledged that he failed to verify the physician order before administering the medication, as required by hospital policy. Staff #305 confirmed with the surveyor that he gave	A 405		

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A 405	Continued From page 100 the correct medication amount and corrected the MAR.	A 405		
A 467	CONTENT OF RECORD: ORDERS,NOTES,REPORTS CFR(s): 482.24(c)(4)(vi) [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition. This STANDARD is not met as evidenced by: Item #1- Provider Orders Based on record review, and review of hospital policy and procedure, the hospital staff failed to document patient care consistent with provider orders. Failure of hospital staff to document patient care activities consistent with provider orders puts patients at risk of harm from inadequate care and monitoring. Findings included: 1. Document review of the hospital's policy titled, "Physician's Orders," effective 05/17, showed that the nurse would transcribe medication and treatment orders.	A 467	**Plan of Correction for Each specific deficiency Cited:** (A 467) The Hospital failed to document. As evidenced by missing documentation. **Procedure/process for implementing the plan of correction:** • Staff and nurses were re-educated on the importance and priority of documentation. This will be conducted no later than April 30, 2018. This includes • Documentation per provider orders. • Documentation on completion per provider order. This includes but not limited to: o Lab completion o Special procedures o I&O • Incident/events documented in the Medical record and to fill out an incident report. • Incident report completed and routed to the CNO. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • 15% of the medical records will be audited five times a week. Auditing will continue until 100% compliance for one month. If compliance goes below the threshold of 70% for 2 months a new corrective action plan	May 23,2018

will be created to address the finding. After 100% compliance is reached for 1 continuous month then spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported to the Director responsible for the identified items for follow up.

- Nursing supervisors will report any events to the CNO and report that documentation in the record was completed accurately.
- Nursing supervisors and managers will ensure that incident reports are filed prior to the end of the shift and given to the CNO.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Data collected from documentation audits will be reported to the PI committee until 100% compliance is achieved for one continuous month. If compliance goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month then spot checks of 2 medical records will be reviewed for the items monthly. Identified issues will be reported to the Director responsible for the identified items for follow up.
- The CNO will ensure that all incidents filed by nursing are reported to the PI director on the daily basis.

Individual Responsible:
John Beall, Chief Nursing Officer
Date Completed:
May 23, 2018

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A 467	Continued From page 101 2. Surveyor #9 reviewed the medical record of Patient #909, who was admitted 03/03/18. At the time of admission, the record showed that the admitting provider ordered measurement of daily intake and output and that the staff should encourage fluid intake. The intake and output records for 03/05, 03/06, 03/07, 03/08, 03/09 showed that the patient's intake of fluid was measured, but there was no measure of the patient's output of fluids consistent with the provider's orders. . 3. Surveyor #9 reviewed the medical record of Patient #910 which showed that the patient had ongoing vaginal bleeding possibly related to being postpartum (after having a baby). On 03/03/18 at 10:25 AM, a provider wrote an order to check the number of pads the patient was using for vaginal bleeding. The medical record review showed no record of a pad count prior to the patient being sent to the Emergency Room for evaluation at 2:30 PM. Item #2- Missing Documentation Based on interview and medical record review, the hospital failed to document necessary information regarding patient safety incidents into patients' medical records. Failure to maintain a complete information about a patient's health status in their medical record risks substandard care and poor outcomes. Findings included: 1. Document review of the hospital's policy titled, "CPR Code Blue," effective date 05/17, showed that all CPR- certified personnel have the	A 467		

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A 467	Continued From page 102 responsibility for initiating emergency resuscitation and maintaining a Code Blue in the event it is required and that a code blue response form is to be utilized and placed in the medical record . Document review of the hospital's policy and procedure titled, "Observation Levels," effective date 05/17, showed that there are specific protocols and required documentation for each observation level. Reasons for the levels of awareness included suicide risk; homicide risk, falls risk, potential for aggressive behavior, or sexually "acting out" behavior. 2. Surveyor #5 reviewed the medical record of Patient #505. The record review showed the following: On 02/16/2018 at 3:15 PM, Patient #505 attempted suicide by hanging himself with his bed sheets. Documentation from a nursing report showed that the patient was found down with a sheet tightened around his neck and staff called a code blue. The report showed that the patient was initially unresponsive but responded to sternal rub and the patient was transported to an Emergency Department at a medical hospital via ambulance Surveyor #5 was unable to locate the Daily Nursing Progress Note and Nursing Assessment for 02/16/18 in the medical record . Surveyor #5 was unable to located the Code Blue documentation in the medical record . On 03/06/18 at 4:00 PM, Surveyor #5 interviewed the Chief Nursing Officer (CNO) (Staff #501)	A 467		

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A 467	Continued From page 103 about the suicide attempt. At the time of the interview, Surveyor #5 and Staff #501 reviewed the chart for patient #505 for the missing documentation, including the Daily Nursing Progress Note and Nursing Assessment for 02/16/18, the Code Blue documentation for the suicide attempt on 02/16/18, and the lack of documentation by nursing about the attempted suicide event in the patient's medical record. Staff #501 confirmed the missing nursing documentation and stated there would be no code documentation because this would not be considered a code. 3. On 03/07/18 at 11:08 AM, Surveyor #5 and a Registered Nurse (Staff #508) reviewed the medical record for Patient #508 who was admitted on 02/15/18 for the treatment of post-traumatic stress disorder, depression, and suicide attempt. The medical record showed the following: The Intake Assessment completed on admission showed that the patient had self-harm behavior, a history of suicide attempts, and had taken a knife with her to her provider appointment and made threats to stab herself. The patient was assessed at high risk for suicide. On 02/17/18 at 11:00 AM, a Psychiatric Progress Note stated, "(Patient #508) attempted to hang herself this a.m., and verbalizes her continued desire to die as she no longer wants to deal with her mental illness." Surveyor #5 found no evidence of this event in the Nursing Progress Notes or Assessment .	A 467		

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A 749	Continued From page 104	A 749	**Plan of Correction for Each specific deficiency Cited:**	
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Item #1- Prevention of water-borne illnesses Based on interview and record review, the hospital failed to implement and carry out components of its water management program. Failure to properly implement all components of the water management program risks patient infection from water-borne pathogens. Findings included: 1. Record review of the hospital policy titled, "Managing Biological Agents in Water Systems (AMME Plan)," Policy #EC.02.05.01.5, showed that hospital staff are required to develop a flow diagram to assess risks within the hospital water system. The review also showed that hospital staff are required to document monitoring results for risk control methods and that the Assessment, Maintenance, Monitoring, and Evaluation (AMME) Committee is required to review the results quarterly. Record review of the hospital document titled, "AMME Monthly Monitoring Plan," showed that the hospital monitors the temperature of the	A 749	(A 749) The Hospital failed to create a flow diagram for the hospital policy. **Procedure/process for implementing the plan of correction:** • Facilities manager created the flow diagram as required in the policy. • Preventative maintenance was created for water storage tank temperature and will be monitored monthly. • The Isolation gowns found in the soiled utility room have been discarded. The isolation gowns are now located in clean utility room. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Quarterly reporting added for both items to the EOC/Safety meeting template and will be reviewed quarterly. As part of the template both identified items will be addressed in the EOC safety committee and then minutes reported to the PI committee monthly for report up to the Governing board at quarterly. • • Isolations gown will be reviewed on the monthly EOC rounds that are conducted on the monthly basis. Any identified gowns found placed in wrong area during EOC rounds or at	May 23,2018

			other time will either be immediately addressed during the rounds or communicated with infection control for follow up. If 3 months of finding the gowns in the soiled utility room are found and identified during the EOC/Safety rounds than a plan of correction will be submitted to the PI committee for review and approval. **Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:** • Policies will be reviewed on an annual basis and approved. • Information will be reported to the EOC/Safety committee. • The flow diagram creation will be reviewed on an annual basis and revised accordingly. • **Individual Responsible:** Zach Keefe, Plant Operations Manager. **Date Completed:** May 23, 2018	

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A 749	Continued From page 105 domestic hot water storage, ice machine cleaning and maintenance, and eyewash station cleaning as risk control methods for the water management plan. Record review of the Environment of Care committee meeting minutes (dates: 05/30/17, 06/19/17, 07/20/17, 08/30/17, 09/27/17, 11/30/17, 12/12/17, and 01/09/18) did not show evidence that the monitoring results were reviewed as described in the hospital's "AMME Monthly Monitoring Plan". 2. On 03/12/18 at 4:10 PM, Surveyor #2 interviewed the Director of Plant Operations (Staff #201) and the Maintenance Technician (Staff #202) regarding the water management program. The surveyor asked the staff members if the hospital had developed a flow diagram of the hospital water system. The maintenance technician stated that a flow diagram had not been developed. The surveyor also asked if staff was monitoring and documenting the risk control methods listed in the water management policy. The technician stated that temperature monitoring of the water storage tanks was conducted visually, but temperatures were not recorded. Maintenance and inspection of the ice machines and eye wash stations was conducted and documented. Item #2- Storage of Isolation Gowns Based on observation and interview, the hospital failed to store staff isolation gowns in a manner that prevented cross-contamination. Failure to protect personal protective equipment from contamination prior to use puts patients and	A 749		

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A 749	Continued From page 106 staff at risk from infection. Findings included: 1. On 03/05/18 at 1:50 PM, Surveyor #4 toured the 2nd floor units of the hospital. The tour included a soiled utility room (B-218). The observation showed isolation gowns and gloves stored on a wall unit inside the soiled utility room. 2. On 03/08/18 at 2:30 PM, Surveyor #4 interviewed the hospital's infection prevention nurse (Staff #404) about the above observation. She stated that isolation gowns should not be stored in the soiled utility room. The hospital provided gloves in the soiled utility room for housekeeping staff to use, but not isolation gowns.	A 749		
A1124	ORGANIZATION OF REHABILITATION SERVICES CFR(s): 482.56(a) The organization of the service must be appropriate to the scope of the services offered . This STANDARD is not met as evidenced by: Based on interview and record review, the hospital failed to provide Occupational Therapy Services in a timely manner when physicians ordered evaluations for 5 of 8 patients (Patients #1102, #1103, #1104, #1105, and #1106). Failure to provide Occupational Therapy Services in a timely manner places patients at risk for decreased function and potential loss of	A1124	**Plan of Correction for Each specific deficiency Cited:** (A1124) The Hospital failed to adequately provide timely and appropriate rehabilitative services as ordered by providers for patients. **Procedure/process for implementing the plan of correction:** • The Director of Clinical Services is responsible for ensuring occupational service needs are met as defined by physician order. • The director of clinical services will obtain services from agencies when unable to meet the needs of internal staffing. **Monitoring and Tracking procedures to ensure the plan of correction is effective:** • Occupational therapy orders will be monitored for completion within 72 hours of order. • Compliance will be audited by the Clinical Services Director 5 days a week for compliance and will be audited until 100% compliance is achieved in one continuous month. If compliance	May 23,2018

goes below the threshold of 70% for 2 months a new corrective action plan will be created to address the finding. After 100% compliance is reached for 1 continuous month then spot checks of 2 medical records will be reviewed for the items monthly. Identified non-compliance will be reported by the Clinical Services director to the PI Committee monthly.

Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:

- Data will be present to the PI committee until100% compliance with physician orders.

Individual Responsible:
Leah Jones, MSW, LICSW, CDP, Director Clinical Services
Date Completed:
May 23, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504012	A. BUILDING _____ B. WING _____	C 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKEY POINT BEHAVIORAL HOSPITAL	3955 156TH ST NE MARYSVILLE, WA 98271

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A1124	Continued From page 107 independence upon discharge. Findings included: 1. Review of the medical record of seven current hospital patients and one discharged patient for timeliness of occupational therapy evaluations showed the following: a. Patient #1102 was a 62 year-old admitted to the hospital on 02/21/18 for treatment of delusional thoughts, depression, and anxiety. Review of the patient's medical record showed that on 02/22/18 at 10:00 AM the patient's provider ordered occupational therapy to assess the patient for cognitive decline and to perform a functional assessment. Hospital staffransferred the patient to a medical center on 3/1/18. There was no occupational therapy consult in the medical record b. Patient #1103 was a 65 year-old admitted to the hospital on 01/24/18. Review of the patient's medical record showed that the patient's provider ordered an occupational therapy evaluation on 02/02/18. An Occupational Therapist evaluated the patient on 02/12/18; ten days after the initial order. c. Patient #1104 was a 73 year-old admitted to the hospital on 02/21/18. The patient's provider ordered an occupational therapy evaluation on 02/24/18. An Occupational Therapist evaluated the patient on 03/12/18; nineteen days after the initial order. d. Patient #1105 was a 52 year-old admitted to the hospital on 01/04/18. The patient's provider ordered an occupational therapy evaluationon	A1124		

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A1124	Continued From page 108	A1124		

02/19/18. Review of the medical record showed that the Occupational Therapist initially saw the patient on 02/19/18 but the evaluation was not completed until 03/12/18; twenty-eight days after the initial order.

e. Patient #1106 was a 74-year-old patient admitted to the hospital on 11/29/17. The patient's provider ordered an occupational therapy evaluation on 01/17/18. Review of the patient's medical record showed that the Occupational Therapist evaluated the patient on 02/12/18; twenty-three days after the initial order.

2. On 03/06/18 at 2:25 PM, Surveyor #11 interviewed a provider (Staff #1101) who provides psychiatric care for patients admitted to the Older Adult Unit (1-West). The provider stated that there was only one Occupational Therapist and they are only at the facility one day per week.

3. On 03/14/18 at 3:30 PM, Surveyor #11 interviewed a Recreational Therapist (Staff #1107) about Occupational Therapy Services. The Recreational Therapist stated that there was only one Occupational Therapist and that they are only at the facility on Mondays. She stated that the Occupational Therapist had been out of the office due to illness. Staff #1107 stated that the hospital needed more occupational therapy hours to meet patient needs.

4. On 03/14/18 at 3:40 PM, Surveyor #11 interviewed the Director of Clinical Services (Staff #1108) about availability of Occupational Therapy Services. The Director of Clinical Services confirmed that the Occupational Therapist was only available on Mondays and had limited ability to perform evaluations on any other day of the

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A1124	Continued From page 109 week. Staff #1108 left the room then returned after speaking with the Chief Executive Officer (Staff #1109). Staff #1108 reported that the Chief Executive Officer told her that the hospital had a contract for Occupational Therapy, Physical Therapy, and Speech Therapy. The Director of Clinical Services stated she did not know about the availability of contracted services prior to the conversation with the Chief Executive Officer. Staff #1108 stated that hospital staff had not utilized the contracted services because hospital administration made the decision to use an Occupational Therapist on an as needed basis instead.	A1124		